

DOCTORAL THESIS

A qualitative study of practitioners' experience of working with bilingual interpreters in providing individual psychotherapy to clients with limited spoken English

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**A QUALITATIVE STUDY OF PRACTITIONERS' EXPERIENCE OF
WORKING WITH BILINGUAL INTERPRETERS IN PROVIDING
INDIVIDUAL PSYCHOTHERAPY TO CLIENTS WITH LIMITED
SPOKEN ENGLISH**

By

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**A THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENT
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To my loving parents Dogan Erbil and Asli Erbil and my sister's Eylem, Ozlem, Meltem and Pinar, thank you all for your thoughtful and encouraging support.

Thank you also to my supervisors for their support and guidance and to the practitioners for taking the time to participant in this study.

ABSTRACT

The focus of this study is on how psychological practitioners including, counselling psychologists, clinical psychologists and other therapists carry out clinical work with bilingual interpreters in offering psychological therapy to clients with limited spoken English. All of the eleven volunteer participants were employed by the National Health Service (NHS), and offered therapy as part of the Improving Access to Psychological Therapy (IAPT) services. All the participants had at least one year of experience working with interpreters. Participants were interviewed and the data was analysed using a social constructionist version of Grounded Theory.

The findings of this study suggest that there is a tension in therapy that is of a triadic nature. This tension seems to be centred on two separate styles of clinical practice. Practitioners oscillated between considering the relational nature of the therapeutic work as an exclusive dyadic relationship consisting of the client and themselves, and as an inclusive triadic relationship with the contributions of the interpreter. More specifically, practitioners appeared to want to hold onto the traditional dyadic practice of therapy which offered familiarity, certainty and consequently a sense of reassurance. In other words, it seemed that by denying the interpreter affirmation to the clinical work, and thus dismissing their potential influence on the process and progress of the work enabled practitioners to continue perceiving themselves as the professional expert in charge of the therapeutic work. However, at times practitioners spoke from a more reflective stance, in which the clinical work was considered as a triadic process involving the three members of the triad and acknowledged the benefits of working with an interpreter which included: having a better understanding of the cultural meanings that are important for the client; being able to offer a better experience of

therapeutic containment; and developing psychological interventions that are client-centred and culturally appropriate.

Overall, the findings suggest that the practitioners in this study struggled to establish their position within the triad. In part, this seemed to be related to the difficulty in negotiating the role of the interpreter in the process of therapy and thus developing a co-worker relationship. It is suggested that clinical work carried out with the help of interpreters could be improved by addressing the areas highlighted in this study and supporting both the therapist and the interpreter in working as a team through implementation, training and regulation of best practice guidelines.

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CHAPTER 1: INTRODUCTION

1.1 General Introduction

The current study builds on the existing literature of how practitioners work with bilingual interpreters, in offering therapy to clients with limited spoken English. In particular, from a social constructionist perspective this study aims to;

- 1) Explore what meanings practitioners assign to the role of the interpreter when working together in offering therapy to clients with limited spoken English.
- 2) To examine how, if at all, does the presence of the interpreter influence the practitioners' perception of themselves as the professional expert within the triad.
- 3) To consider the wider social factors and how these possibly influence practitioners' experience of working with interpreters in the triadic system of therapy.

This chapter begins by explaining the rationale for this study, putting it in context and highlighting its importance to the field of counselling psychology. Certain terms used by the researcher throughout this study are then defined, including: the practitioner, the interpreter, ethnic population or communities, and the therapeutic dyad and the therapeutic triad. The chapter will conclude with a summary of the chapters to follow.

1.2 General Context and Rationale for the Study

As the European Union extends its membership to include new countries and given the various socio-political tensions across the world, people are moving across borders. The latest immigration statistics from the Home Office published in May 2015 indicate that there were 25,020 asylum applications (main applicants) in the year ending March 2015, a rise of 5% compared with the previous year (23,803). The report states that most

applications for asylum are made by those already living in the country (89% of applications in the year ending March 2015) rather than people arriving at port. In addition, according to the 2011 Census, the Black, Asian Minority Ethnic population is 14.1% of the overall total in England and Wales, rising from 7.9% in 2001. This does not include the significant ‘white other’ population which is now 2.5 million (4.4%) of the overall population. As a result, modern Britain is becoming ever more culturally and linguistically diverse. In response to the changing population the demand for ethnic communities to have access to healthcare, and with this the need for bilingual interpreters across the health care settings has increased (Raval, 1996). Consequently, many psychological practitioners, including counselling psychologists find themselves working with language interpreters. This being the case the field of counselling psychology needs to question the appropriateness of its clinical application of theory that is embedded in western ideology (Patel & Fatimilehin, 1999; Patel, 2003). If counselling psychology as a discipline is to foster equal opportunities, anti-discrimination and to be ethically sound, then it is crucial for it to scrutinise its own practice in how well it meets the needs of today’s society.

Current literature on the use of interpreters in clinical practice indicates that the mere presence of a third person changes relational dynamics and has implications for the whole therapeutic process (Raval, 1996; Tribe, 1999; Mudarikiri, 2003; Patel, 2003; Pugh & Vetere, 2009; Tribe & Tunariu, 2009). Most of the available research in this area has tended to adopt an Interpretative Phenomenological Analysis (IPA) to offer an in-depth understanding of the practitioner’s subjective experience of working with interpreters (Raval, 2000; Raval & Smith, 2003). However, these studies do not necessarily account for the potential influence of the social interaction between the members of the triad in creating the meanings and beliefs practitioners associate to their experience. In contrast this

study takes a social constructionist perspective to the grounded theory method to address the issue of how practitioners work with bilingual interpreters in offering therapy to clients with limited spoken English. It aims to explore how practitioners negotiate both their role and position with that of the interpreter, and how this in turn potentially affects their experience of working within the triadic system of therapy.

1.3 General Overview of the Study and Use of Terminology

This study proposes to interview counselling psychologists, clinical psychologists and various other therapists employed by five NHS founded Improving Access to Psychological Therapies (IAPT) services located across three major boroughs of London, including both inner city and suburban areas formed of diverse multi- ethnic communities. It might be argued that there are differences in the training, accreditation and philosophical principles underpinning these different professions. However, the researcher takes the view that all psychological practitioners are fundamentally trained in understanding psychological functions of the human mind and its representations in human behaviour. Consequently, the term practitioner or therapist is used interchangeably throughout this study to refer to psychological professionals including, counselling psychologists, clinical psychologists and other therapists who offer psychological support to clients. The term therapy refers to the clinical application of psychological theories of human nature as practiced by these professionals.

The complexity and the inherent difficulties of the task of interpretation have also been studied by some authors (Roy, 1992; Tribe, 1999). Literal translation of words across different languages may not always be possible thus it is suggested that at best the interpreter provides an approximation of the client's remarks and emotions (Rea, 2004). Although the terms interpreter and translator are commonly used interchangeably,

translation typically refers to converting text between two languages; whilst the role of the interpreter is not to simply translate what is said word for word, but rather involves interpreting what they hear into meaningful language with “*attention to idiosyncratic meaning accompanying nonverbal communication, and the cultural significance of spoken communication*” (Searight & Searight, 2009: p.445). For the purpose of this research the term interpreter is used rather than that of translator.

The term ethnic population or communities is used to include the Black, Asian, Minority and White Other population who require the assistance of a language interpreter due to limited spoken English. Finally, dyadic therapy refers to the psychotherapeutic relationship as being inclusive to only the therapist and the client. In contrast, the triad includes the actual presence of the interpreter within this relationship and is used to reflect the triadic nature of the interaction between the therapist, the interpreter and the client.

1.4 A Brief Overview of the Chapters that follow

Chapter 2: Literature Review

This chapter begins with an overview of the mental health provisions for service users from Black, Asian, Minority, Ethnic (BAME) communities and related to this the provisions of the IAPT services. The current available literature and research relevant to improving access to psychological/talking therapies is considered, with particular reference to the importance of developing culturally sensitive services. The chapter concludes by presenting a critical review of the notion of professionalism and highlights the potential power inequalities in therapeutic practice.

Chapter 3: Methodology and Method

The chapter starts with the rationale for the choice of research methodology and method. The principles of social constructionism (Gergen, 1992; Burr, 2003) and symbolic interactionism (Mead, 1934; Blumer, 1969) that underpin this study are discussed in relation to alternative theories of empirical enquiry. The decision to collect and analyse data using a constructionist grounded theory method (Charmaz, 2006) is discussed and contrasted with other qualitative research methods such as discourse analysis and IPA. The potential contradiction and critics in grounded theory are then presented. Finally, a description of the method of enquiring the data and its analysis is offered to illustrate how the findings of this study were grounded within the data.

Chapter 4: Results

The findings of the data analysis are presented in this chapter, with supporting quotes from the participant's interview transcripts. This chapter details the formation of the focus codes, categories and core categories leading to the construction of a theoretical model about the different therapeutic styles and positions practitioners take when working with bilingual interpreters in offering therapy to clients with limited spoken English.

Chapter 5: Discussion

In this chapter the findings of the grounded theory analysis are discussed further under the category headings and evaluated in light of existing literature. In concluding this study the limitations of the findings and the use of research method is discussed. Suggestions for improvements, as well as future research avenues are explored.

CHAPTER 2: LITERATURE REVIEW

This chapter presents the recent literature in the areas that are of particular interest for this research. The strategy taken for this academic review involved using the learning resource centres of Roehampton University, NHS trust and University of Hertfordshire to accumulate published journal articles, books and research papers from prominent authors in the area of clinical work carried out with the aid of bilingual interpreters. Furthermore, certain professional organisations such as the British Psychology Society was contacted to obtain various published resources including the professional guidelines for practitioners and for information regarding the professional training curriculum. Online journals and other national government websites were made use of to access information on national statistics regarding ethnic communities living in the United Kingdom and also for information on equal opportunity legislations relevant to national health care provisions in particular to the Improving Access to Psychological Therapy (IAPT) services. Finally, data was requested from the IAPT services under the Freedom of Information Act regarding the communities that access the service and the percentage of the service users who require the help of an interpreter; as well as the general role of interpreters within the organisation.

To begin with this chapter considers some of the issues concerning the national health care provision for service users from Black, Asian and Minority Ethnic (BAME) communities. Barriers to accessing psychological/ talking therapies for service users whose spoken English is limited is considered in relation to the importance of adopting culturally appropriate intervention strategies. The existing literature on the work carried out with interpreters in health care settings, and the potential advantages and drawbacks of this work is discussed with particular reference to the British Psychological Society (BPS)

professional practice guidelines for working with interpreters. This chapter concludes with a critical review of the notion of professionalism and draws attention to the potential power games in the clinical practice of therapy.

2.1 Mental Health Provisions for Service Users from Black, Asian and Ethnic Communities

The recent trends in migration mean that Britain is a multicultural society that “*contains a richness and diversity of languages, cultures and beliefs or views*” (Tribe, 2007, p.159). Consequently, the growth of ethnic and cultural diversity has led to an increase in the demand for people from all communities to have equal access to high quality national health care services (Raval, 1996). However, the use of the word *equal* is important as in the case of mental health provisions the evidence suggests that members of BAME communities are less likely to access such services (Sue, 1977), and when they do these occasions are more likely to involve the police and emergency services (Breux & Ryujin, 1999). Furthermore, in comparison to non-migrants, the proportion of compulsory and secure-unit admission for migrants is higher (Owusu-Bempah & Howitt, 2000; Lindert, Ocak-Schouler, Heinz & Priebe, 2008; Selkirk, Quayle & Rothwell, 2012). This supports the argument that mental health services are failing to provide equitable access across ethnic communities (O’Neil, Kaufert, Kaufert & Koolage, 1993; Fernando, 1995; British Psychological Society Race & Culture Sig, 1995).

Authors have highlighted those factors that might act as a barrier for members of BAME communities from accessing mental health services. These include: not having access to information regarding available services; not knowing how to access such services; not being able to speak the common language, and being subjected to social stigma from other members of their community for accessing mental health services (Carr, 1997; Corsellis,

1997; Selkirk et al., 2012). In addition, some authors claim that the theoretical frameworks informing many mental health practices are not responsive to the service user's cultural context. It is argued that these services are culturally inappropriate and potentially increase the risk of members of BAME communities from experiencing further discrimination, racism and disempowerment in the process of accessing mental health provisions (Crawford, 1994; O'Neil et al., 1993; Fernando, 2005; Loewenthal, Mohamed, Mukhopadhyay, Ganesh, & Thomas, 2010). Indeed, Owusu-Bempah and Howitt (2000) claim that one explanation for the lack of voluntary utilization of psychological mental health services by BAME communities is because of the cultural inappropriateness of these services and the treatments on offer. In order to counter the situation where the service user's experience of disempowerment might be re-enacted in the therapeutic relationship, practitioners are encouraged to be explicit with service users regarding issues of power. It is argued that this will open the space for service users to talk openly about their experience of racism and discrimination (Ridley, 1995; Aitken, 1998; Drennan, 1999).

Overall, it is argued that local mental health provisions need to take a greater account of the broader socio-political context if they are to offer services that are culturally appropriate and be able to meet the needs of the service user's from BAME communities (Crawford, 1994; Corsellis, 1997; Loewenthal et al., 2010; Selkirk et al., 2012).

2.2 A Brief Introduction to Improving Access to Psychological Therapies.

The low uptake of psychological/talking therapies by BAME communities has been highlighted as a key issue by the Department of Health (2007), which it has been argued needs to change (Mulatu & Berry, 2001) if equality in mental health care across ethnic communities is to be achieved. The Improving Access to Psychological Therapy (IAPT) is a large-scale government funded initiative that aims to improve access to psychological

therapies, primarily Cognitive Behavioural Therapy (CBT), for common mental health problems, within NHS-commissioned services in England (Department of Health, 2012). This national project was launched following recommendations made by the Layard Report (2004) which publicised the lack of provision of mental health services in meeting public demand and the economic cost of this to the UK. In 2011, the government launched its mental health strategy, '*No Health without Mental Health*' to both ease the burden on NHS mental health services as well as the wider economy (HM Government & Department of Health, 2011). This cross-government outcomes strategy committed more than £400 million over four years (up to 2014/15) to significantly improve equitable access to high-quality talking therapies. Layard (2006) estimated that in its full-scale operation by the end of 2014, around 800,000 people will be able to access and benefit from the psychological support offered by the IAPT services.

Since its initial launch in 2008, the IAPT programme is now established in every area of England. At present there are forty-three IAPT services in London. For the purpose of this study five IAPT services that operate across three culturally and linguistically diverse London boroughs and located in multiple primary care sites were approached. The IAPT data from the last financial year ending 2013/14 indicates that these services worked with 11,716 people and that there were over 50 different languages spoken by service users accessing these particular IAPT services. Other than English (9,646), service users also commonly requested therapy in Farsi /Persian (259), Polish (149), Turkish (679) and Spanish (107).

2.3 A Review and Critique of Improving Access to Psychological Services for Service Users from Black, Asian and Minority Ethnic communities

Given the various different languages spoken by people accessing psychological therapies some authors claim that a person's cultural and linguistic background can act as a barrier to accessing health services (Murray & Buller, 2007; Saha, Fernandez & Perez-Stable, 2007). In relation to this, a study carried out by Loewenthal, Mohamed, Mukhopadhyay, Ganesh, and Thomas (2010) investigated the feasibility of accessing IAPT services for the Bengali, Urdu, Tamil and Somali speaking communities. The findings suggest that potential barriers to improving access for these communities exist, including the difference in cultural and religious interpretation of mental health problems and the stigma associated with mental health illnesses. To differing degrees, participants across the four community groups did not agree with what may be considered western medical conceptions of depression and anxiety. For example, depression was conceptualised by the Somali community as being indistinguishable from everyday life struggles, and anxiety was considered as a non-clinical disorder. Similarly, because there is no directly equivalent concept of anxiety available in Urdu, the female members of this community struggled to recognise what may be considered western conceptions of anxiety. Language was also identified as posing a barrier. Although, across the four focus communities participants expressed that they were generally wary of interpreters, and wanted the freedom and independence to communicate directly with the health practitioner, most of the participants also acknowledged the importance of provision of professionally trained interpreters in increasing access to psychological therapies. With particular reference to IAPT, the above study highlights the potential problems that arise in imposing conceptualisation of common mental health disorders such as 'anxiety' and 'depression' and the design of psychological treatment based on this model in creating services that are culturally insensitive and thus not recognised or considered relevant to communities outside that of the dominant culture. Overall, as well as highlighting the importance of the provision of high quality language

interpretation services to enable access for service users with limited English, the authors suggest that in creating culturally sensitive services IAPT teams need to build better relations with the local ethnic communities they serve.

Support for the need to create culturally sensitive mental health services, as recommended by Loewenthal et al., (2010) is offered by a more recent study which sought to investigate how Polish migrants in Scotland conceptualised distress and how this, in turn, influenced their decisions about whether to seek psychological support (Selkirk, Quayle, & Rothwell, 2012). Although the focus of Selkirk et al., (2012) study was not specific to the context of IAPT services and some of the participants were able to communicate their needs in English, the findings nonetheless suggest that there are a number of cultural factors that influence Polish migrants' decision about whether to take up psychological help. In particular, the authors suggest that Polish migrants' sense of identity, which developed in interaction with cultural norms and values that emphasise family relationships, community networks and traditional perceptions of male and female gender roles, influenced participants' decision to seek emotional support. Importantly, approaching services for psychological support was incongruent with traditional cultural values, and those participants who strongly identified with these values rejected psychological services as a possible option, preferring to either work through their problems in private or within their social network. In comparison, participants who questioned traditional Polish cultural values and engaged in social groups where therapy was considered more socially acceptable were more open to the option of accessing professional support, although there was still a preference to approach a Polish therapist in the private sector. The findings also suggest that past experience in using NHS services both in Scotland and in Poland influenced the likelihood of participants' willingness to access psychological support. For

instance, participants who were disappointed with the treatments they had previously received by the Scottish primary care services were reluctant to approach the NHS for help with emotional difficulties, while those who were satisfied seemed more open to this possibility. The authors concluded that psychological services would be well-placed to work with this group by considering ways to build partnerships with community agencies that migrants were more comfortable approaching.

The findings of these studies highlight the importance of developing culturally sensitive services in both improving access to psychological therapies and in offering treatment programmes that are relevant and appropriate to service users from BAME communities. According to Rea, (2004) the question of what needs to be done to develop accurate and appropriate interventions that are culturally contextualised and can address differences in language and meaning deserves serious attention. She argues that unless this question is addressed, it is unlikely that psychologists will be able to offer effective therapeutic services to individuals from minority ethnic groups.

In addition to building good links with communities in developing culturally informed services there is also a need for psychological practitioners to be able to offer culturally-sensitive psychological interventions. The increasing socio-demographic shift towards cultural diversity necessitates the need for psychological practitioners to be culturally competent in their clinical practice (Whaley & Davis, 2007), and is often acknowledged as being an important component of professional training. Guarnaccia and Rodriguez (1996) highlight the lack of attention given to conceptualising culture within professional training curricula and in the development of culturally competent mental health services. Whaley and Davis (2007) argue that an important first step in planning a culturally competent mental health service is to identify the fundamental principles of the notion of culture.

Most definitions of culture emphasize the socially shared aspects of traditions, ways of living, coping behaviours, values, norms, and beliefs which are passed from generation to generation (Miranda, Nakamura & Bernal, 2003; Whaley, 2003; Thompson, 2005). Culture is defined by Guarnaccia and Rodriguez (1996) as a “*dynamic and creative phenomenon, some aspects of which are shared by large groups of people and other aspects which are the creation of small groups and individuals resulting from particular life circumstances and histories*”(p.433). Others have defined culture as the values, beliefs and practices learned and socially shared by a community of individuals who consequently share a particular view of the world and hold interpretations central to the meaning of their lives and actions (López, Grover, Holland, Johnson, Kain, & Kanel, 1989; Howard, 1991). Modern definitions of culture also acknowledge the interconnection of different cultures and their respective modification as a result of living in multicultural societies (Guarnaccia & Rodriguez, 1996; Hermans & Kempen, 1998; Thompson, 2005).

The literature offers several definitions of cultural competence. López (1997) states that cultural competence is “*the ability of the therapist to move between two cultural perspectives in understanding the culturally based meaning of clients from diverse cultural backgrounds*” (p.573). In essence cultural competence can be considered as a set of congruent behaviours, attitudes and policies that enables a system, agency or group of professionals to work effectively in cross-cultural situations (Cross, Brazen, Dennis, & Isaacs, 1989) and is considered by many as a lifelong process during which the person continuously develops cultural awareness, knowledge and skills (BPS, 2014; Eleftheriadou, 2002; López, 1997; Pedersen, 2001). The literature on cultural competence suggests that practitioners need to be aware of how differences in communication, worldview, relations and definitions of health can affect the therapeutic encounter and outcome (Cross et al.,

1989; Sue, Arredondo, & McDavis, 1992). In addition, practitioners are required to acquire knowledge of theory and practice relevant to cross-cultural therapeutic encounters and be aware of attributes of specific cultural groups that they might work with (Campinha-Bacote, 2002; Lo & Fung, 2003). Such awareness and knowledge is important in making culture-centred adjustment in therapeutic practice and is considered as an important skill in the development of a therapeutic alliance, as well as, enhancing communication, developing a shared understanding, and offering appropriate psychological interventions (Sue et al., 1992; Bassey, 2011). Cultural competence, as in the ability to adapt therapeutic practice sensitively and provide equitable access for people from diverse cultures, is recognised as an essential element of practitioners overall professional competence (Department of Health, 2008). Indeed, with regard to working with diversity and cultural competence the BPS standards for doctoral programmes in counselling psychology states that by the end of the programme, trainees will be able to;

“Develop an understanding of the importance of cultural and ethnic backgrounds and an awareness of difference including visible, less visible, and mixed backgrounds, and be able to work from a knowledge base of different cultural framework” (BPS, 2014, P.23).

Furthermore, the Black and Asian Counselling Psychologists’ Group (BACPG) argue that psychologist can no longer ignore the need to work with a multicultural and multiracial society and that as a profession we need to recognise both the richness and the challenges this poses to clinical practice. Consequently, Eleftheriadou (2014) supports the recommendation to widen the scope of counselling psychology training to explicitly include a formal module on every counselling psychology course to adequately address the concepts and embrace the values of race, culture, ethnicity and diversity. It is suggested

that the module would give trainees the opportunity to understand the complexity of racial and cultural issues and how these impact on our lives and more significantly how they emerge in clinical practice. Such a module would offer a foundation for trainees to better contextualise their clients in relation to their individual values, beliefs behaviour and thinking.

There is little research on whether the IAPT specific training programme for CBT therapists actually facilitates the development of cultural competence in practitioners. To address this gap Bassey and Melliush (2012) carried out a study to investigate IAPT CBT therapists' views on how their training informed their practice in delivering CBT to BAME communities, and whether their views on the relevance and influence of culture in their practice is consistent with the literature on cultural competence. Overall, the findings were consistent with literature on cultural competence frameworks as therapists' demonstrated sensitivity to the dimensions in which differences could exist between themselves and their clients. However, the findings suggest that there is observable tension resulting from different perspectives on how to best meet the needs of service users from BAME communities. This tension exists in both the technical and ethical domains. In particular, some therapists stated that the model of CBT and its rationale did not suit their clients and described having to move away from certain facets of the model to accommodate their clients' needs, whilst others felt that the client needs to take on certain assumptions implicit within the model, if CBT is to work. Some tension was also evident in the difference of opinion regarding what ethical responsibilities rest with the therapist in offering CBT to service users from BAME communities. Some of the therapists felt that rather than proactively building a knowledge base for particular ethnic groups, cultural issues relevant to a particular client should be determined in each specific case. Developing such a

knowledge base was considered by some of the therapists to be unnecessary as it potentially risked increasing the likelihood of stereotyping and making general false assumptions about an individual. This position alternated with the view that awareness of cultural traditions, beliefs, and values of a group provides background knowledge and thus helps to contextualise the person's experience and facilitate shared understanding. Despite these differences in how best to work with service users the authors suggest that in addition to a personal motivation to learn about cultural issues, clinical experience acquired in a diverse community can act as an important contributor to cultural competence. Furthermore, the authors suggest that training programmes can supplement cultural competence by allowing adequate time and supervision to attend to trainees' needs to discuss cultural influences in their practice and through introducing learning exercises that reflect on cultural issues.

Furthermore, when offering psychological support to BAME communities one needs to consider the extent to which particular psychological interventions that have empirical support are actually efficacious with service users from these communities. As well as being the most common form of empirically supported intervention in the literature, CBT is also the main psychological intervention offered by the IAPT services (Rosselló & Bernal, 1999; Atkinson, Bui & Mori, 2001; Hall, 2001; Pina, Silverman, Fuentes, Kurtines, & Weems, 2003). It has been argued that significant adaptations in the delivery of therapy, in terms of the inclusion of cultural knowledge, attitudes and behaviours are needed to make empirically supported interventions more culturally appropriate (Atkinson et al., 2001; Miranda et al., 2003). In support of this, a study by Organista, Muñoz and Gonzalez (1994) found that service users from BAME communities receiving CBT provided by the NHS opted out of treatment more frequently than their non-minority counterparts.

Similarly, Miranda, Bernal, Lau, Kohn, Hwang and La Fromboise (2005) found that only 36% of low-income women from BAME communities who were randomly assigned to CBT actually attended six or more sessions. In contrast, a study by Miranda, Green, Krupnick, Chung, Siddique, Beslin and Revicik, (2006) provides a good example of the various types of cultural adaptations that can be made in the application of psychological therapy, and offers evidence to suggest the effectiveness of CBT interventions that have been culturally adapted to reflect the service user's cultural experience. In this study of psychological intervention for depression in low income minority women, a number of modifications at various levels including, service delivery, the nature of the therapeutic relationship and the application of techniques were made. For instance, prior to offering CBT, participants received a number of educational sessions about depression and its treatment, and certain aspects of CBT were adjusted both linguistically and by using culturally specific examples in techniques. The findings suggest that, compared with standard approaches, psychological interventions which are culturally adapted to be more compatible with the cultural experiences of clients from BAME communities can be more effective in meeting the needs of BAME clients.

This section has focused on the need for, and the importance of improving access to psychological therapies for clients from BAME communities. It appears that barriers to equal access to mental health services still exist. Although cultural competence and cultural adaptation are suggested as methods of improving mental health services, the key issue of how to develop services that are culturally sensitive and therefore better able to meet the needs of clients from BAME communities, still remains to be fully addressed within clinical practice.

2.4 A Review of Existing Literature on Working with Interpreters across Language and Culture in Mental Health Services

As the National Health Service strives to offer mental health services that are inclusive, accessible and appropriate to members of all ethnic communities, the need for language interpreters in bridging potential gaps in service provisions is apparent. In line with the BPS standards on cultural competence for counselling psychology training curriculum which states that trainees should be able to *value social inclusion and demonstrate a commitment to equal opportunity* (BPS, 2014, P.23), the BPS good practice guidelines recommends that all psychologist should receive training in working with interpreters as part of their core professional training or as part of their ongoing continuing professional development so as to ensure that certain groups are not being denied access to psychological services on grounds of language (Tribe & Thompson, 2008).

A working partnership between psychological practitioners and interpreters can enrich clinical practice through the many opportunities this partnership can offer in terms of broadening clinical perspectives and skills in service delivery, as well as building culturally sensitive services (Tribe, 2007; Tribe & Lane, 2009; Tribe & Tunariu, 2009; Meeuwesen, Twilt, Thijs & Harmsen, 2010). A recent qualitative research carried out by Barron, Holterman, Shipster, Batson and Alam, (2010) explored the views of members of the Pakistani, Bangladeshi and Chinese communities regarding the primary health care interpreting provisions based at two localities in Hertfordshire. The findings indicate that members of these communities were unaware of the provisions for healthcare professionals to arrange interpreting for their primary health care consultations. Consequently, members of these communities usually managed with the assistance of family members, including children, and friends. The appropriateness of using children to access health care was

questioned, particularly given that women reported having to invent illnesses rather than talk openly about embarrassing health issues in the presence of their children or husband. Participants indicated a preference for using professional interpreters who were from their own gender and culture and identified trust, accuracy, independence and confidentiality as being important attributes for professional interpreters.

In the field of mental health, research by Raval and Smith (2003) used interpretative phenomenological analysis (IPA) to explore mental health practitioners' experience of offering therapy with the aid of an interpreter. The findings of this study suggest that practitioners' experience difficulty in establishing a working alliance with an interpreter and, in turn, this has a negative impact on establishing a working alliance with the client. Although, practitioners were aware of the need to establish a co-worker alliance and seemed to want to develop a type of co-therapist working relationship with the interpreter, they had serious doubts as to whether, in practice, this could be achieved. The difficulty in establishing a good working alliance between the practitioner and the interpreter was associated with limitations on both practitioners' and interpreters' time; poor integration of interpreters into the service; the implicit power inequalities inherent in the context of NHS work, as in the low professional status assigned to the interpreter, and the general lack of trust practitioners have towards interpreters. Ironically, whilst being in a position of potential power, practitioners spoke of feeling sidelined to the client-interpreter relationship and felt anxious with the loss of direct communication. They experienced a sense of not being in control of the situation and thought that they had little power to change the conditions under which interpreters were contracted to work with them. Raval and Smith (2003) report that practitioners and interpreters seem to be caught in a complementary relationship defined as one in which; "*inequality and the maximization of*

differences exist” (p.24). Overall, the authors argue that a closer co-worker alliance between the practitioner and the interpreter is crucial to providing the necessary level of containment for the service user to feel safe enough to engage in therapy. Raval and Smith (2003) suggest that many of the challenges in establishing a good co-worker alliance can be overcome by allowing sufficient time to plan the work; clarifying the responsibility of the practitioner and the interpreter, and through building additional time at the end of a session to reflect on the work that has taken place. The process of communication through interpretation and the potential impact of this on the clinical work were also explored by Raval and Smith (2003). Practitioners spoke of how the process of translation significantly influenced their ability to use their full range of therapeutic and personal styles. In addition, practitioners explained that due to the difficulties associated with engaging in in-depth therapeutic work through an interpreter, they often drew on practical interventions which are both present focused and problem focused. The findings suggest that simplifying psychological interventions in this way was done by all participants, irrespective of whether the practitioner worked from a behavioural, systemic or psychoanalytic orientation.

A further issue in offering psychological support with the help of an interpreter has been the accuracy of the translation being provided and whether there is any difference between a professional and an informal interpreter. Some authors claim that there is little difference in discourse structure between formal and informal interpreters and argue that informal interpreters actually contribute to attaining trust between the practitioner and service user (Green, Free, Bhavnani, & Newman, 2005; Greenhalgh, Robb, & Scambler, 2006; Rosenberg, Seller, & Leanza, 2008). However, because of fewer translation errors made and greater practitioner and service user satisfaction, the majority of the literature on health

care interpreting recommends the use of professional interpreters as opposed to family members or friends (Farooq & Fear, 2003; Flores, 2005; Jacobs, 2006; Tribe & Tunariu, 2008; Tribe & Lane, 2009). In line with this, the BPS professional practice guidelines for working with interpreters suggest that where possible the client and interpreter should be matched in age and gender; a child should never act as an interpreter nor the client's relative (Tribe & Thompson, 2008).

Roberts, Moss, Wass, Sarangi and Jones (2005) have shown that most miscommunication in intercultural practitioner-service user encounters in primary care consultations occurs as a result of talking styles. Cultural differences between the service user and the practitioner can become manifest in the style of self-presentation, that is the way in which the practitioner and the service user structure information and manage the encounter.

Meeuwesen, Twilt, Thijs and Harmsen (2010) suggest that a relevant distinction might be in language structure (such as grammar and vocabulary) or cultural differences, in that service users from BAME communities may structure and organise information in another way than practitioners do (for example, by first explaining the context and towards the end of the consultation indicating their reason for accessing the service).

Given these distinctions in language structure and the potential variations across the different cultures, in terms of the style in which information is presented; the question arises as to how an interpreter facilitates the mutual understanding between the practitioner and the service user. According to Kaufert (1990) a meaningful and seamless translation requires the interpreter to carry out a number of skilful activities such as eliciting information, simplifying language, contextualising the meaning behind the communication, and clarifying what has been said. In addition, an interpreter needs to account for the complexities that are inherent to each culture and language and how this in turn manifests

in the different ways people express their feelings at both the verbal and non-verbal level (Lago & Thompson, 1996).

Given the complexity of the task carried out by interpreters their role and responsibility within the clinical work has often been a controversial subject. According to Bot (2005) in the process of mediating communication an interpreter can select one of two main approaches, the '*translator-machine*' model and the liberal '*interactive*' model. As the name suggests, in the interactive model the interpreter takes on an active stance towards the interpreter-mediated clinical encounter, whilst in the first model the interpreter is present as a non-person acting as a translation machine. Following a review of the codes of ethics developed for medical interpreters Kaufert and Putsch (1997) conclude that in the process of mediating communication, interpreters are encouraged to take on an objective and neutral role. This is in line with traditional conceptualisation of the role of an interpreter as, "*a 'conduit' transmitting messages between parties reliably and without distortion*" (Dysart-Gale, 2005, p.92). In essence the 'conduit model' requires the interpreter to perform in a machine-like manner rendering in one language literally what has been said in the other in a neutral and faithful manner without any personal addition in terms of omission, editing or polishing (Roat, Putsch, & Lucero, 1997). This 'conduit-machine model', which often requires the interpreter to use the first-person singular, minimizes the presence of the interpreter thus creating the illusion of a dyadic practitioner-service user communication. Research on the practice of medical interpreters, however, suggests that interpreters often do not act like a neutral translation machine, but rather, tend to participate in the interaction as a third interlocutor (Angelelli, 2004; Davidson, 2000). Wadensjö (1992) distinguishes three types of roles that the interpreter can take on, in the process of mediating communication these are: the '*reporter*', which is similar to the role

in the translator-machine; the '*recapitulator*', where the interpreter might change the original utterance, but its content remains the same, and the '*responder*', in which the interpreter reacts directly to an utterance by the primary speaker, on their own accord, and no translation actually takes place. In these situations, where the interpreter steps out of the 'conduit –machine' role, a dyadic communication takes place in which either the practitioner or the client is excluded from the interaction and hence could potentially experience exclusion. However, some authors would argue that a successful interpreter-mediated encounter requires interpreters to take on roles other than a 'conduit-machine', such as a cultural broker, and claim that this is often required to facilitate interactions where the practitioner and service user may have cultural differences and expectations (Hatton & Webb, 1993; Davidson, 2000; Dysart-Gale, 2005).

In contrast to prior research, which has often focused on the interpreter as being solely responsible for the quality of the bilingual interaction, Hsieh (2006) asserts that some of the non-neutral performances of interpreters may be caused by their efforts to resolve conflicts in their role requirements that arise from others' expectations of them. Hsieh (2006) carried out 26 in-depth interviews with medical interpreters across 17 languages to explore interpreters' understanding of their role. The grounded theory (Strauss & Corbin, 1998) analysis generated rich data highlighting that although many of the interpreters strive to be invisible in the practitioner-service user interaction, this nonetheless was found to create challenges and dilemmas as several interpreters in the study experienced conflict about the role they perform. Owing to the limitations imposed by institutional constraints, such as, institutional culture, hierarchy, policies and regulations, and feeling powerless to challenge others expectation of them, interpreters felt bound to the role of a 'conduit-machine'. However, taking this position created problems for interpreters, for instance they

often experienced conflict from having to take on the role of an emotionless professional (as in the conduit-machine) whilst feeling emotionally attached to the client's narrative. Furthermore, Hsieh (2006) argues that each member of this three-way interaction is equally responsible for the quality of the communication. Therefore, in contrast to other research in the field of interpreter mediated medical encounters, she suggests that the responsibility to maintain shared understanding between members cannot be the interpreter's responsibility alone. Hsieh's (2006) study illustrates the interdependency of all individuals in this three-way communication process as they constantly negotiate, (re)define and coordinate relationships, and identities in the process of social interaction. From a grounded theory perspective Hsieh (2006) argues that individuals' communicative behaviour is interdependent. She draws attention to contextual factors such as institutional culture and policies and their potential influence on how the role of the interpreter is negotiated by individuals in this three-way communication process of social interaction. In short, Hsieh's (2006) research is significant because it explores interpreter mediated communication from a perspective that accounts for contextual factors and other speakers' behaviour in a way that had not been investigated in previous research.

2.5 The Macro level Social Power and its Influence within the Clinical Context of Therapy

Steffen and Hanley (2013) claim that, as a discipline psychology needs to better account for the interplay between social power and the individual. Therefore this section will look at power in relation to social inequalities and in doing so, aims to draw attention to how power and inequalities on a macro level can enter and be played out between the practitioner, the interpreter and the client within the context of the therapy room.

Literature on the work carried out with the help of a bilingual interpreter often concentrates on clients from a refugee background (Papadopoulos, 2003; Patel, 2003; Tribe, 2007). In addition to the array of pre-migration experience, such as political violence, war, torture and imprisonment that most refugees' experience, research suggests that, exile-related or post-migration stressors, including social oppression in the host country, are responsible for much of the observed distress among refugees. Tribe and Keefe's (2009) description of the refugee experience as involving, "*multiple losses, not least of their country, family, sense of identity, status, culture, support systems and often the fundamental ability to communicate easily with other people through a shared language*" (p.414) helps to explain why this group in society are particularly vulnerable to mental health problems. Generally research on refugee mental health has centred on the psychological impact of pre-migration related experience (Venables & Rodriguez, 1989; Drozdek & Wilson, 2004; Blackwell, 2005). However, Al-Roubaiy, Owen-Pugh and Wheeler (2013) assert that explaining the distress observed among refugees primarily by the impact of negative pre-migration factors can underrate, "*the complexity of how pre-migration and post-migration factors can interact in giving rise to*" (p.54) mental health problems such as post traumatic stress disorder and generalised anxiety disorder. The importance of exile related difficulties experienced by refugees has been explored by Miller (1999) who identified four major exile-related sources of distress including, social isolation; loss of social and occupational role and related to this loss of meaningful activity; loss of environmental mastery and loss of material and financial resources. More recently a qualitative study carried out by Al-Roubaiy et al., (2013) explored how Iraqi refugee men living in Sweden experience, and manage, exile-related stress. The findings mainly centred on participants' experiences of various forms of social oppression. In particular, participants expressed feeling disempowered, marginalised and racially discriminated by Swedish society. In dealing with

exile-related stress participants described the value of social support from fellow Iraqis as well as the importance of maintaining links with Iraq and sustaining Iraqi culture.

It is possible that the client's experience of disempowerment through social oppression is re-enacted in the context of offering psychological support through the aid of an interpreter. Firstly, in order to receive the support available the client requires the help of an interpreter and is therefore not only dependent on the therapist for psychological relief, but is also relying on the interpreter to communicate their experience; this can heighten the client's sense of disempowerment. Harrison (2013) points out to how cultural norms are affected by power and warns therapists against making assumptions about a client's thoughts, emotions and behaviour on the basis of their own views and beliefs. She encourages therapists to take care and be careful not, *"to label a behaviour or an emotion without understanding the broader cultural aspects of the specific world the client inhabits [as doing so] can lead to misunderstanding and a power imbalance"* (Harrison, 2013, p.111). Patel (2003) points out that when working with clients from non-western backgrounds it is important for professionals to question the validity and usefulness of western psychological theories and models, which are inevitably culturally-bound and biased. Indeed, Patel and Fatimilehin (1999) describe the inappropriate application of inherently biased models of therapy to clients from certain non-western ethnic communities as a form of secondary colonisation. A process whereby, within the therapeutic context and guise of professional help the already marginalised person is inadvertently further oppressed and disempowered by having to fit to the dominant discourse of therapy. Other authors have also drawn attention to the potential power inequalities that still exists in the therapist-client relationship (Masson, 1993; McLeod,

2011; Harrison, 2013). With particular reference to working with refugees, Patel (2003) criticises psychological knowledge and the therapeutic stance of neutrality for

“Focusing on individual distress as if it has arisen in, and exists in a vacuum devoid of socio-political contexts [and] for ignoring the historical and socio-political contexts within which human rights abuses have arisen and which are maintained to date, thereby defending and legitimating the ideologies and practices that result in the continued exploitation, oppression and violation of marginalised peoples” (Patel, 2003, p.221).

In a recent theoretical paper, Edwards (2013) explored the topic of power dynamics in the clinical practice of therapy through three different types of power that are applicable to the field of therapeutic practice. These are: ‘*role power*’, inherent in the role of the therapist in comparison to that of the client and the interpreter; ‘*societal power*’, which accounts for the power distribution in society with regards to the structural position in society of the therapist, the client and the interpreter; and finally ‘*historical power*’ which refers to the therapist’s, the client’s and the interpreter’s personal experience of power and disempowerment. As a result of the knowledge and skills enquired during clinical training the role of the therapist can be described as one of authority (Proctor, 2002). The danger of the power associated with this role is described by Miller and Rollnick (2002) as the ‘expert trap’ in that the therapist takes up the role of the expert and assumes that he or she is all knowing and has all the answers to the client’s problems. In taking up such a role, the therapist undermines both the client’s resources and responsibility for resolving his or her difficulties and the skills and knowledge of the interpreter, who is an expert and professional in their own right. In the event that the therapist slips into the ‘expert trap’ the client and the interpreter can feel disempowered. Reflecting on personal experience in

practicing therapy Edwards (2013) suggests that, to avoid the risk of slipping into the 'expert trap' a therapist needs to be self-aware and vigilant, in addition to a commitment to sharing power in the clinical work. It can be argued that the notion of expertise and professionalism, which themselves are socially constructed, benefits the practitioner, offering "*a clearly defined, respectable package that can be sold*" (Rikonen & Vataja, 1999, p.180). In defence, practitioners would argue that clients and interpreters themselves have a part to play in creating the existing power dynamics within therapy as before work even begins they have an expectation of the practitioner as the professional expert (Totton, 2009). However, House (1999) warns that the professionalization of counselling psychology can lead to abuse of power by practitioners through the imposition of 'expert knowledge' and the encouragement of a dependent transference.

Societal power, as described earlier, accounts for the structural position in society of the therapist, the client and the interpreter and its influence on the power dynamics in therapy is evident even before therapy starts as it helps to set the clinical context (Proctor, 2002). The introduction of IAPT services means that therapy is offered in NHS settings with long waiting times to work with a therapist and many aspects of the therapeutic contract are set in advance through pre-determined protocols. Consequently, the therapist is initially considered by the client and the interpreter as being in a superior position to them. Foucault (1980) argues that since society cannot completely eradicate the power of some groups over others it may be better to explore how this domination can be minimised. This can potentially be done through collaboratively working with both clients and interpreters in the development of the NHS psychotherapeutic services available, and through therapist self-awareness in recognising that biases in therapy exist and being mindful of their own biases and its potential influence in clinical practice (Spinelli, 2005; Edwards, 2013).

Finally, historical power is concerned with how the therapist's, the client's and the interpreter's personal experiences of power and powerlessness can affect and to a degree determine the therapeutic work and relational dynamics (Proctor, 2002). The therapist, the client and the interpreter would have had previous experience of being in a position of disempowerment and have had previous encounters with individuals that are considered to be in a position of authority; this will inevitably affect how members of the triad behave towards each other and this in turn will influence and determine the therapeutic alliance and outcome. According to Edwards (2013) it is important to recognise that within the therapeutic encounter each member's intention and self-awareness can act as a critical component in how power is negotiated. This view compliments the modernist position of power dynamics as being multi-directional, recognising that each member of the therapeutic encounter has valuable knowledge and skills. In conclusion Edwards (2013) acknowledges the potential advantage of self-awareness on the part of each member of the therapeutic encounter, as well as the need to work collaboratively in reducing the client's distress.

This chapter has presented some of the topics that are important in the area of working with interpreters in offering psychological support to clients with limited spoken English. It is apparent that this area has predominantly been explored through in-depth analysis of therapists', clients' and interpreters' personal experience using IPA. The exception to this is Hsieh (2006) study which introduced a social perspective to this clinical area. However, this study focused on medical interpreters and although there are some similarities between a medical consultation and a therapeutic encounter, for example, both are based in the premise of confidentiality, there are nonetheless many differences most obviously it can be argued that the therapeutic relationship differs much to the relationship between a general

practitioner and the patient. This study aims to contribute to the literature on how practitioners work with interpreters in offering therapy to clients with limited spoken English. In particular, from a social constructionist perspective the research aims are;

1) Explore what meanings practitioners assign to the role of the interpreter when working together in offering therapy to clients with limited spoken English.

The current literature on clinical work carried out with the aid of an interpreter indicates that in the process of translating, the interpreter can assume a number of different roles. Whilst some authors suggest that the interpreter should strictly remain as a neutral conduit translator device, others argue that interpreters form an important part of the professional team and that the role of the interpreter is much more diverse, as they are often in a position to act as a cultural informer. Consequently, given this contradiction, it is important to explore how the practitioner evaluates the role of the interpreter. This is particularly important from a social constructionist perspective as it becomes possible to explore and better understand how social roles and personal identities are socially constructed in the process of social interaction and, how these assigned roles can potentially influence people's relationships and behaviours towards each other. For instance, if the practitioner assumes that the role of the interpreter is no more than that of a translating machine then how does this role conceptualisation influence the professional working relationship between the practitioner and the interpreter?

2) To examine how, if at all, does the presence of the interpreter influence practitioners' perception and identity of themselves as the professional expert, within the triad.

Both the BPS and the IAPT training programmes expect practitioners to value social inclusion, to be competent in offering therapy cross culturally and to demonstrate a

commitment to equal opportunities. Furthermore, the BPS offers professional guidelines on how best to work with interpreters to establish ways of working together to offer equal access to psychological services. However, research literature suggests that although there are benefits of incorporating interpreting services to clinical practice, in terms of upholding equal opportunities, the presence of an interpreter has considerable clinical implication. Most notably, according to current literature, practitioners continue to struggle with having a third person in the consulting room. It is therefore important to explore in what ways the presence of the interpreter influences the practitioners clinical style and more specifically to examine the positive and negative implications the presence of the interpreter has on the practitioners own identity as a professional therapist. This will help to identify any gaps in training that requires further attention in supporting trainees and practitioners to feel confident in their professional identity, and competent in working with other professionals when offering therapy to clients from different cultural and linguistic backgrounds to their own.

3) To consider the wider social factors and how these possibly influence practitioners' experience of working with interpreters in the triadic system of therapy.

The literature on the macro level social power indicates that issues of power, discrimination and oppression inevitably forms part of the clinical work. These are perhaps more prominent in the clinical triad between the three members and the triangular interaction. Authors argue that the current evidence based culture of the NHS results in unrealistic expectation and puts pressure on practitioners to demonstrate their professional worth in what has become a highly competitive, time limited and overall demanding NHS mental health services. Therefore, in considering the triadic style of therapy it is important to evaluate the implication of the wider societal context and identify some of the implicit

and explicit social factors that affect practitioners' experience of offering psychological therapy in the clinical context of a triad with regard to how the practitioner views and relates to the interpreter.

The following chapter describes the chosen methodology and method for this study. This is followed by the results in Chapter Four and in Chapter Five the findings are discussed in relation to existing literature in this area.

CHAPTER 3: METHODOLOGY AND METHOD

This research adopts the social constructionist grounded theory method as proposed by Charmaz (2006). The distinguishing characteristics of grounded theory method include: (1) the simultaneous involvement in data collection and its analysis phases of research; (2) adopting a 'bottom-up' approach by constructing analytic codes and categories developed from and grounded in the data, rather than from preconceived hypothesis; (3) memo-writing which involves writing analytic notes to explicate categories, specify their properties, define relationships between categories, and identify gaps; (4) theoretical sampling, that is, targeted sampling aimed towards theory construction rather than attempting to achieve representativeness of a given population; (5) acknowledging the influence of the researcher on both the data collection and analysis (Charmaz, 2001, 2006). There are four main parts to the present chapter. First, a brief outline of the ontological and epistemological positioning of social constructionism and symbolic interactionism is offered, and this is used as a context for describing the more salient aspects of these approaches as they apply to this study. Second, the epistemological position taken by the researcher and the rationale for the choice of method is discussed by comparing this methodology to others in the qualitative field. Third, the context and data collection for this research is described including; the research context, ethical approval, the background of the researcher, the interview schedule and the wider ethical issues surrounding this area of clinical work are identified. The chapter concludes with a description of the method, including the design, sample population, sampling procedure, and the instrumentation of the study.

3.1 Methodology

Methodology here is taken to mean the ontological and epistemological assumptions that underpin this research. The social constructionist grounded theory method (Charmaz, 2006) used to investigate the phenomenon inevitably influenced the way the data was both gathered and analysed.

3.1.1 Issues relating to Ontology and Epistemology

The scientific status of psychology and matters concerning its methodology, ethics, sampling, and research objectivity are often considered in the context of ontology and epistemology. In psychology the debate concerning the philosophical nature of existence, or reality has included two main arguments. One which argues that objects exist independently of human perception, and the other which proposes that there is no way of perceiving reality, as it is, other than that which exists in social processes, structures and institutions (Collier, 1998; Willig, 1998). The argument surrounding the debate on ontology reflects the various positions taken in psychology concerning the origin, nature, and limits of human knowledge. For the purpose of this study, these will be considered in terms of two broad perspectives namely that of positivist and constructionist epistemology (Henwood & Pidgeon, 1992).

From a positivist perspective it is possible to generate objective knowledge about the true nature of reality through the use of hypothetico-deductive scientific investigation that is objective, factual, value-free, predictive and rests on universal understandings about the 'real or material' world (Morgan, 1996). This position therefore assumes that true knowledge about reality can be achieved through rigorous scientific research procedures that make it possible to control for researcher biases, culture and subjective assumption

from having an influence on the data. In contrast to this position, the constructionist perspective, argues that human knowledge is subjective and embedded in the contextual aspects of a given social world including; language, culture and historical time. It is therefore, only possible to access subjective representation of reality as it is constructed in the process of social engagement. As a result, according to this perspective, the focus of social science needs to be on how accounts about the world are constructed through the course of social relationships and actions (Woolgar, 1996; Burr, 1998; Burr, 2003). It is important to understand that from this stance the objection is not that there exists a reality outside of perception (realism), but rather to the claim that the truth about that reality can be accurately measured and defined through the use of hypothetico-deductive scientific research methods (Crotty, 1998). Therefore, whilst from the positivist stance it is possible to reject subjective knowledge as being relative, fictional and unscientific, the constructionist position challenges the notion of a singular truth and objectivity, claiming that reality is subjective, determined by language, interaction and social constructions. The constructionist position claims that it is not possible to reach reality as it exist in the objective world through the use of such tools as experimental test and statistics. This perspective therefore argues that the application of traditional empirical methods to study the social world of humans is, “*at best a pious hope or else an illusionary lie*” (Hoffman, 1992, p.7).

3.1.2 Social Constructionism in relation to Grounded Theory

This section outlines the social constructionist principles with reference to the grounded theory approach and considers its relevance to this research. At its foundation the social constructionist position challenges the view that conventional knowledge is based upon objective, unbiased observation of the world. Rather the social constructionist position

proposes that the very categories and concepts we use to understand the world are the products of that particular culture and history, and are dependent on the prevailing social and economic arrangements of that time. In its application to grounded theory this argument seems to support Charmaz's (2001) claim that, even if 'appropriate measures' are taken, it is not possible to eliminate the subjectivity of the researcher from influencing the research, thus it is better to accept and acknowledge the (co)construction of the research data and its findings as representative of both the participant and the researcher. In essence, the social constructionist argue that what is regarded as truth varies historically and cross-culturally, and simply reflects what is at that time accepted ways of understanding the world. Therefore, this approach cautions us to be more suspicious of the assumption that the nature of the world can be revealed through 'objective scientific observation' arguing that these so called 'truths' come about through the social processes by which subjective knowledge is produced from a network of social interchange that take place within culture and social relationships (Henwood & Nicolson, 1995; Hoffman, 1992). Therefore, according to Charmaz (2000) taking a social constructionist perspective to grounded theory helps loosen its methodological tie to "*a realist ontology and positivist epistemology*" (Charmaz, 2000, p.513), because her version of grounded theory permits "*examining processes, making the study of action central, and creating abstract interpretive understandings of the data*" (Charmaz, 2006, p.9) and thus takes a more interpretative stance, in which the interactive influence of the researcher is acknowledged. Finally, because the social constructionists posit that knowledge evolves in the space between people, in the realm of the common world, it follows that from this position grounded theory is concerned with exploring the process in which meanings about the world are construed in the social realm between people. The emphasis is thus on process than discovering the essential nature of humans or the underlining truths of society. Pidgeon

(1996) highlights this point in stating that the social constructionist grounded theory views “*scientific process as generating working hypotheses rather than immutable empirical facts; and [holds] an attitude towards theorizing that emphasizes the grounding of concepts in data rather than their imposition in terms of a ‘piori’ theory*” (Pidgeon, 1996, p. 80). The ontological roots of social constructionism with its acceptance of multiple, socially constructed realities and its epistemological stance that recognises the “*mutual creation of knowledge by the viewer and the viewed*” (Charmaz, 2000, p.510) is helpful for this study in understanding the inherent multiplicity of meanings that can be attributed to practitioners experience of working in the triad with an interpreter. First, there is the construction of reality and meanings that practitioners attribute to their clinical experience of the triad that is construed in the process of the contextual and relational dynamics of the triad with the influence of the interpreter’s perspective and the client’s perspective; but there are also the meanings that become (re)constructed about this experience within the interview process with the researcher. Thus the social constructionist view of multiple realities and the continuous (re)construction of this reality in the process of social interaction is a useful research paradigm for this study.

3.1.3 Symbolic Interactionism in relation to Grounded theory

The principles of the grounded theory method incorporate the pragmatist philosophical tradition that informed symbolic interactionism (Blumer, 1969). In essence this theoretical perspective assumes that “*society, reality, and self are constructed through interaction and thus rely on language and communication*” (Charmaz, 2006, p.7). Similar to social constructionism, symbolic interactionism sees the individual’s social world as a vast continuous process, in which the meanings of objects are socially formed, sustained and transformed through group interactions. That is, the nature and the meaning of any object

comes to being through the way it is defined to the person, for whom it is an object, by those with whom the person interacts with. Like other objects, the nature of self is also considered to emerge from the process of social interaction. In keeping with the symbolic interactionist perspective Charmaz (1983) argues that the “*self is fundamentally social in nature [because it] is developed and maintained through social relations*” (p.170). She assumes that “*social identities derive from cultural meanings and community memberships and are conferred upon the person by others*” (Charmaz, 1994, p.269). Therefore a symbolic interactionist would argue that a person sees or defines himself according to the way in which others see and define him, and in doing so the person becomes an object and is able to engage in social ‘role-taking’. Blumer (1969) suggests that this process of social ‘role-taking’ is important for social interaction because it not only determines the actions one takes towards others, but also enables the person to engage in ‘self-talk’, a form of communication whereby the person addresses himself. Given this fundamental symbolic interactionism assumption about the social nature of the self, the therapeutic triad potentially offers a unique group context in which to examine the formation of a person’s social identity or self-concept through the process of a relational social interaction. More specifically, within the triadic framework each member takes on a ‘social role’ that is (co)constructed, sustained and (re)constructed in the process of therapy; what is more, by examining how each person’s identity is formed through group interaction it is possible to evaluate how each person’s socially constructed identity might, in turn influence his or her perception of, and behaviour towards other group members. Furthermore, from a social constructionist perspective it becomes possible to examine the extent to which a member’s social identity is consistent with wider social ideas around what constitutes a particular social role. For example, what is involved and socially required of a person who takes on the social role of a ‘professional’ or an ‘expert’ within a social group situation.

At its core symbolic interactionism sees the individual's social world as involving the interplay of significant objects, symbols, gestures and systems of meaning that are interpreted in the process of social interaction and through 'internal conversation' or 'self-talk' (Blumer, 1969). Upholding the principles of symbolic interactionism, grounded theory assumes that interaction is inherently dynamic and interpretative, and is concerned with how meanings and actions are created, enacted, and transformed in the social world between people. These symbolic interactionist assumptions underpin the analytic research in grounded theory as exemplified in the research of Charmaz (1983, 1994, 1995) examining the self in relation to chronic illness and physical disability.

3.1.4 Symbolic Interactionism and Social Constructionism in relation to the present study

For research to be considered scientific it has traditionally been necessary to meet the requirements of reliability and repeatability. In the field of psychology, this has often led to adopting a positivist epistemology to research through the application of such methods that aim to standardise data collection, and rule out investigator influence (Morgan, 1996, 1998; McLeod, 2003; Fassinger, 2005). However, in accordance with the principles of symbolic interactionism and social constructionism, this research adopts an interpretative epistemology arguing that science should include the art of interpretation and meaning generation, and that trying to ensure repeatability can take the data out of context, therefore contradicting validity (Sherrard, 1997). These perspectives emphasise the fluidity of meanings and recognise the vital importance of social interaction as people negotiate meanings of objects in a given social context. Thus the researcher is encouraged to consider how meanings are construed in the process of social interaction. In keeping with these perspectives, Charmaz (2001) claims "*that the interaction between the researcher and the researched 'produces' the data*" (p.339) and explicitly states that her approach

“assumes that any theoretical rendering offers an interpretive portrayal of the studied world, not an exact picture of it” (Charmaz, 2006, p.10).

Given that historically what was considered to be science has changed over the years, Woolgar (1996) suggests that perhaps it is better to understand science as being the ways in which people understand their world, at any given time. This supports the constructionist grounded theory as proposed by Charmaz (2006) assuming that *“research participants’ implicit meanings, experiential views-and researchrs’ finished grounded theories- are construction of reality”* (p.10). Therefore, in keeping with the social constructionist grounded theory it needs to be acknowledged that the construction of meanings or theories from this study is based on the researcher’s subjective and interpretative analysis of the data. Recognising that each stage of inquiry was influenced by the researcher’s assumptions, interactions and unique interpretation it is possible therefore, that another researcher might have taken a different route of enquiry, or perceived alternative themes as more prominent (Charmaz, 2001, 2006). Consequently, the interpretative framework of meanings put forward by this researcher do not constitute a final reality but are in themselves constructions, albeit ones that endeavour to be grounded in the data.

3.1.5 Conclusion from the Debate

The debate between quantitative and qualitative methodology or as it is sometimes referred to as the ‘objective observer’ vs. ‘participant observer’ (Raval, 2000) is an ongoing and perhaps endless one. Needless to say that like most debates it is more helpful to see the two as different ends of a continuum, representing the distance placed between the researcher and the participant or data. Similar to other qualitative methodology, Charmaz’s (2006) constructionist grounded theory method encourage the researcher to be explicit about the influence he or she had in the construction of meanings generated from the research data,

thus promoting reflexivity and transparency in the process of empirical research (Elliott, Fischer & Rennie, 1999; Charmaz, 2006).

Although appearing to be at odds to one another, both the quantitative and qualitative methodologies involve an interpretative process. Both methodologies involve a process of giving meaning to the data albeit through different means. Thus, both are susceptible to a certain degree of subjectivity in the interpretation of the data analysed, and in the choice and application of the selected methodology. Considering that both the quantitative and qualitative paradigms have their strengths and weaknesses in its application to study certain research areas Raval (2000) suggests that a better angle of approaching this debate is to carefully consider the phenomenon and research question one hopes to answer. It is then possible to select the appropriate methodology to be able to answer the particular research question.

3.2 The Epistemological Position of the Researcher and the Choice of Method

The epistemological position taken by the researcher is that of Social Constructionist and Symbolic Interactionist Grounded Theory.

3.2.1 Choice of Method

The social constructionist grounded theory method was considered most appropriate for this study because it fits the overall aim of this research. That is, to develop a better understanding of practitioners' experience of the therapeutic work carried out with the help of an interpreter in a way that account for how the triadic style of therapy is constructed, and how meanings are made in the process of social interaction. This approach also best reflects the researcher's view of therapy as "*a social phenomenon, is something that is constructed between two or more people- a process, action and interaction involving*

indeterminacy, multiple realities and interpretations” (McCreddie & Payne, 2010, p.782). It was considered that from a social constructionist perspective, the grounded theory approach could capture the dual process of how meanings about this area of clinical work are (co)constructed between the participants of the triad, as well as their (co)construction in the process of the interview talk with the researcher. More specifically, adopting Charmaz’s (2006) constructionist style of grounded theory that remains with the symbolic interactionism focus on interaction, action and process, offers an opportunity for the researcher to look both at the interview, in and of itself, and the constructions that are taking place in the moment of the interview, whilst also acknowledging that the experiences are reportable accounts of constructions that takes place in the process of the therapeutic triad. Therefore, the analysis of the interview data adopts a ‘both/and’ rather than an ‘either/or’, in that the researcher is analysing both the constructions that occur in the interview room but also uses the interview data as offering a window onto the dynamic interaction processes that are taking place in therapy. The tension arising from taking this ‘both/and’ position, to a degree, reflects the current grounded theory debate between critical realist (traditional) and relativist (or evolved) ontological perspectives (McCreddie & Payne, 2010). This tension is acknowledged by the researcher and discussed in detail both later in this chapter and also in the ‘post-analytical reflections’ section in chapter 4.

Although many of the qualitative research methods share similar epistemological features and are comparable in terms of data collection techniques, interviewing strategies and analytical procedures, there are also important distinctions between them. A number of research methods that are well established in the field of qualitative research including, interpretative phenomenological analysis and discourse analysis were considered for this research, but for the purpose of this study the constructionist grounded theory method

(Charmaz, 2006) seemed most appropriate. The aim of the present study was to construct a theoretical model about how practitioners' experience working in the therapeutic triad, in a way that accounts for how meaning about that experience are constructed in the process of social interaction (Charmaz, 2006). Given that the available literature and research on how therapists work with interpreters has often adopted Interpretative Phenomenological Analysis (IPA) (Raval, 2000; Raval & Smith, 2003) this qualitative methodology was also considered for this study. Eatough and Smith (2008) explain that IPA endorses social constructionism claim that sociocultural and historical processes are crucial to how people experience and understand their lives. Furthermore, Eatough and Smith (2008) claim that IPA's particular take on social constructionism owes more to symbolic interactionism than poststructuralism, in that similar to symbolic interactionism, IPA recognises the action oriented nature of talk and the dependence of a person's reality to the language of one's culture. However, "*for IPA the lived life with its many vicissitudes is much more than historically situated linguistic interactions between people*" (Eatough & Smith, 2008, p.184). IPA is primarily concerned with the experiential world of the person and aims to provide a detailed exploration of how the person makes sense of their lived experience (Eatough & Smith, 2006). Overall, IPA was not chosen for two main reasons. Firstly, the focus of this study was on the construction of reality and how meanings are construed in the process of social interaction between people, rather than on examining "*reality as it appears to and is made meaningful for the individual*" (Eatough & Smith, 2006, p.324). Secondly, the aim of this research was to generate ideas leading to a feasible theory reflecting the societal factors influencing the social process in question, as opposed to focusing on the phenomenological underpinnings of the personal experience of participants (Wimpenny & Gass, 2000).

Another alternative methodology was discourse analysis, which examines the association between language and human action. In particular, discourse analysis examines how the meaning of words and text represents a certain social and political practice within a given society (Potter & Wetherell, 1987), and it is often used to consider how pre-existing dominant discourses are used to achieve certain social goals (Billig, 1997). This methodology focuses on text and the importance of language in how it can both shape and reflect group life. Whilst language is important to understanding how meanings are negotiated between people, discourse analysis was considered unsuitable for this research, because the aim here is to develop a feasible working hypothesis examining the underlying societal factors that may potentially influence practitioners' experience of working with an interpreter, in the clinical context of a triad as it is (re)constructed in the interview process with the researcher. Furthermore, Charmaz (2001) suggests that the grounded theory method is able to attend to the task of developing theory that is conceptually rich and contextually grounded in data and "*has relevance to the area of study*" (Charmaz, 2001, p.351).

The grounded theory method is unique in that it makes it possible to integrate theory with practice through "*the construction of theory from the lived experience of participants*" (Fassinger, 2005, p.165). This method takes a 'bottom-up' approach to research. Rather than testing preconceived concepts or hypotheses, it places a greater emphasis on theory building through allowing for theory to develop from the qualitative analysis that is undertaken (Pidgeon, 1996; Strauss & Corbin, 1998; Wimpenny & Gass, 2000). Although still carrying these fundamental principles, Charmaz's (2001, 2006) constructionist grounded theory considers theory building as a dynamic process constructed in the discourse between the researcher and the participant. The present study proposes a possible extension to

Charmaz's (2006) style of grounded theory, by suggesting that it is possible to treat interview data in two ways at once, in both looking for what is occurring in the place of the interview, as in the constructions that are produced there to do with actions within the interview, as well as treating it as a frame for exploring the constructions occurring within the therapy room.

3.2.2 Constructionist Grounded Theory: Contradiction and Critics

Different grounded theorists approach the grounded theory method in different ways. For Charmaz (2000) this variation can be characterised as objectivist and constructivist grounded theory methods. On the other hand, Glaser (2002) considers his style as reflecting the more classical properties of grounded theory that “*originated for generating a conceptual theory about say, a basic social process [such as marriage] that is about a concept*” (p.7). He claims that Charmaz's (2000) constructionist version remodels grounded theory offering a descriptive procedure for qualitative data analysis. This section aims to illustrate the differences between Charmaz's (2006) and Glaser's (2002) style of grounded theory, and also attends to the inherent tension in this study that arise from the application and extension of Charmaz's (2006) version of grounded theory.

According to Charmaz (2001) the researcher's influence on the data is inescapable, thus she accepts that the results from any empirical research are representative of both the researcher's and participants' worldview and assumptions. She therefore argues for a constructionist grounded theory that recognises

“That the viewer creates the data and ensuing analysis through interaction with the viewed. Data do not provide a window on reality. Rather, the ‘discovered’ reality arises from the interactive process and its temporal, cultural, and structural contexts.

Researcher and subjects frame that interaction and confer meaning upon it. The viewer then is part of what is viewed rather than separate from it. Because objectivist grounded theorists depart from this position, this crucial difference reflects the positivist leaning in their studies” (Charmaz, 2000, pp.523-524).

Therefore the constructionist grounded theory emphasise the researcher-participant dyad and the (co)construction of data because it assumes that people construct the realities in which they participant in. Conversely, Glaser (2002) argues that grounded theory is not solely a constructionist enterprise. He asserts that through careful implementation of the grounded theory techniques it is possible to generate “*theory as objective as humanly possible*” (Glaser, 2002, p.5). Glaser (2002) argues that in her attempt to solve the ‘worrisome accuracy’ problem of qualitative data analysis by proposing that data is a mutual (re)constructed interpretation of reality, Charmaz (2000) actually remodels grounded theory. Glaser (2002) posits that Charmaz (2000) neglects the properties of abstraction analysis, that involves the careful application of the constant comparative method and theoretical sampling procedures that are central to grounded theory. According to Glaser (2002) through the tedium application of these fundamental procedures, researcher biasing is minimised to the point of irrelevance making grounded theory, a theory about conceptualising latent pattern. Therefore Glaser (2002) asserts that in addressing the issue of objectivist vs. constructionist grounded theory, Charmaz (2000) remodels “*grounded theory from a conceptual theory to a qualitative data analysis conceptual description method*” (Glaser, 2002, p.10). Overall, according to Glaser (1978) the role of the researcher is that of expert or conceptual innovator, and that the researcher can guard against potential subjective biases from posing a threat to the rigor of the study by upholding theoretical sensitivity and following grounded theory procedures. In contrast,

the constructionist perspective does not fear the contamination of data because the researcher is viewed as actively (co)constructing the data, hence is not necessarily viewed as an expert in relation to the participant. Although Glaser (2002) claims that Charmaz's (2000) constructionist take on grounded theory is actually another qualitative data analysis model, he notes that his criticism is intended to demonstrate the difference in choice of method rather than claim that either one is better than the other.

It is important to mention here that a potential tension arises in the manner in which the constructionist grounded theory (Charmaz, 2006) was applied to the analysis of the interview data presented in this study. The strength of adopting the grounded theory method as proposed by Charmaz (2006) permits the researcher to explore constructions in the interview as being mutually construed between the research participant and the researcher but the present study also proposes that the interview data can tell us something about the constructions that take place in the therapy room. In other words, constructions in the interview talk involve constructions and contradictions that may be in the therapy room. This raises a problem in Charmaz's (2006) style of grounded theory as endorsed in this study. In the research outlined here, the researcher aims to bring a kind of social constructionism with subjective realism, hence there is an element of realism, in that the interview talk says something about the dynamic relational processes in which meanings are constructed in the therapy room, and an element of constructionism, in that meanings are constructed in the moment of the interview in the interaction taking place between the research participant and researcher. This potential tension is readdressed in the 'post-analytical reflections' section, in chapter 4.

Although Charmaz (2006) speaks of codes as 'emerging' from the data this view appears to contradict the social constructionist epistemology which assumes that meanings are

socially constructed between people. For this reason the researcher refers to codes and categories as being ‘constructed’. This fits well with the assumption that the data is the result of the interaction between the participant and the researcher and that the analysis is influenced by the researcher’s own inherent biases including, past social experiences, culture and personal perspective. Thus, this terminology not only emphasises the impact of the researcher at each stage of this study, but also honours the importance of researcher reflexivity in the overall process of empirical research (Finlay, 2002). The importance of the researcher’s reflexivity and its potential impact on this research is indicated later in this chapter with regard to the use of memos, and is also discussed in greater depth in chapter 5.

3.3 The Context and Data Collection for the Research

In this section a brief overview of the process of the data collection is offered followed by a more detailed account.

3.3.1 Brief Overview of the Data Collection

The data for this study was collected from clinical practitioners employed by five NHS IAPT services. These services were based in both inner-city and suburban London boroughs and served diverse multi-cultural ethnic communities. At times practitioners worked with bilingual interpreters in order to offer therapy to clients who required the service of professional interpreters to be able to access psychological intervention. Prior to approaching these particular IAPT services a number of different possible sources were exhausted including registered charities, secondary NHS services and professional organisations governing psychological practitioners. Once the study was granted ethical approval by the NHS ethics committee all the clinical practitioners were sent an email inviting them to participate in the study. Those who expressed an interest and met the

inclusion criteria for the research were sent further information and arrangements were made for them to attend an interview. A total of eleven practitioners volunteered to participant in this research. All the participants were interviewed at their usual clinical work setting. The semi-structured qualitative interview consisted of a few open ended questions, giving the practitioners the freedom and flexibility to discuss their clinical experience and thoughts regarding the therapeutic triad as they pleased. The interview commenced once the participant was informed of the ethical obligations of confidentiality and their right to withdraw from the study. This information was also provided in a written format as part of the consent form. The interviews tended to end once all the research questions were addressed and the discussion came to a natural close. Each participant was fully debriefed and the interview content was transcribed and subjected to qualitative analysis.

3.3.2 The Research Context

For the purpose of this research five IAPT (Improving Access to Psychological Therapies) services were chosen. The mental health IAPT service is part of the government initiative to provide better and wider access to psychological therapies within the scope of the primary care NHS service. The five IAPT services are the result of collaboration between two NHS health care trusts. The IAPT teams are based across three different greater London boroughs, formed of both inner-city and suburban areas, which are made up of multi- ethnic communities. These five IAPT services were chosen because they are located in multi-cultural ethnic communities and work with social groups that require the service of professional interpreters to access health care provisions. These were the only services, known to the researcher at the time of the research, which offers psychological therapies with the aid of an interpreter. It was hoped that by selecting these particular IAPT services

which share similar organisational structure and are required to follow the same policies and procedures of the overseeing NHS trust, would allow a greater consistency in the work context from which the participants were drawn from. Therefore the potential requirements, demands and pressures of working with interpreters applied equally to all participants. The potential drawback of recruiting participants that hold a similar experience is discussed later on, when considering the limitations of this study (section 5.5.6). These particular IAPT multi-disciplinary teams were comprised of psychological wellbeing practitioners, high intensity cognitive behavioural therapists, clinical and counselling psychologists, and professionally trained therapists from various different therapeutic disciplines. The IAPT teams operate on a step care design, providing both low and high intensity Cognitive Behavioural Therapy (CBT) treatment and different types of psychotherapy on either a one-to-one or group basis. The IAPT teams were situated across the main primary care NHS service sites and interviews took place either at the primary care GP practice, from which the practitioner worked or at one of the five IAPT regional offices where the teams are based. In order to follow equal opportunity protocols and to ensure that non-fluency in English does not act as a barrier for accessing psychological support, the general IAPT guidelines suggest that in certain cases interpreters may be required and commissioners may want to offer training on working with interpreters. In addition to culture sensitivity and the delivery of psychological therapies across cultures, it is also recommended that IAPT training courses cover ways of working effectively with interpreters and the clinical implications of this working partnership. However, each commissioning trust is responsible for evaluating the communities that the IAPT teams serve and allocate the necessary provisions to be able to meet the needs of service users. With regards to these five IAPT services, where necessary, practitioners were expected to work with interpreters, regardless of whether they had training or experience of this

working style. At the time of this research being conducted there were no employed in-house interpreters that worked specifically within or across any of the five teams.

Interpreters were booked from the general NHS trust pool or other NHS approved agencies, and practitioners were responsible for arranging the interpreter for their own clinical work.

3.3.3 Recruitment of Participants for This Study

In recruiting participants for this study a number of different organisations were sourced. As an initial starting point registered charities were approached, such as Nafsiyat the intercultural therapy centre and national mental health charity, Mind, which is based at various London inner-city boroughs formed of culturally diverse communities. However, attempts to recruit from these organisations were fruitless as it became apparent that due to financial issues the charity Mind was not in a position to fund interpreters to meet service user needs, but did offer therapy in certain languages through bilingual therapist. Similarly, although Nafsiyat worked with multicultural communities and offered therapy in different languages, this was only possible if there was a professional member that was bilingual and spoke the same language as the client. Also, in a hope to recruit participants a small advert briefly detailing the purpose of this study was posted via the BPS division of counselling, however, this raised no interest. As a result the researcher looked into NHS mental health services. At the time the researcher was offering therapy at the NHS community mental health team in Hertfordshire. Although this was a large service working across Hertfordshire with different ethnic communities none of the practitioners reported the need to work with interpreters. Having exhausted the above options, the IAPT services were approached and it was later identified that the IAPT teams within a London based NHS trust offered therapy to clients with the help of bilingual interpreters. Once the IAPT ethics

committee approved the study (see appendix II), all professionals who were working in these five services were sent an email regarding the nature of this study. The inclusion criteria for this study were that participants were registered to a recognised professional body governing psychologists and/or therapists and that they were in clinical practice with a minimum of 12 months experience of offering psychological therapy to clients with the support of an interpreter. Participants who met the study requirements and were willing to take part in the research interview were sent further information and asked to contact the researcher to arrange a suitable interview date and time. A total of eleven participants were interviewed for this study.

3.3.4 Ethical Approval

This study was granted ethical approval from both Roehampton University (see appendix I) and also from the IAPT ethics committee which is governed by the two NHS health care trusts (see appendix II). The participants were informed about confidentiality and signed a written consent form for the interview to proceed (see appendix III). The participants were informed that they may end the interview at any time of their choosing and withdraw from the study if they wished. Written consent was also sought for the interviews to be transcribed and the analysis of these to be reported here, and any subsequent publications arising out of this dissertation. Participants also received information regarding relevant organisations and appropriate individuals that could be approached if they were affected as a result of taking part in the interview and required further support.

Finally, information was also given regarding the necessary steps that would be taken to protect participants' true identities. This included using a numbered coding system on the transcribed interviews and pseudonyms which are used throughout this dissertation.

3.3.5 Wider Ethical concerns

There are a number of ethical issues that need to be considered in relation to this study. In a recent paper, Tribe and Keefe (2009) discuss issues around working with interpreters in therapeutic work with refugees. They highlight that there are clinical, ethical, moral, professional and legal obligations that requires serious attention when working with interpreters in offering therapeutic support to clients. Although this study was not specifically concerned with clients of a refugee status, the issues highlighted in Tribe and Keefe's (2009) paper nonetheless has relevance to this study. Firstly, there is the issue of fair and equal access to health care as many clients who have limited spoken English require the service of an interpreter to gain access to psychological services. Indeed, as mentioned in the literature review, research suggests that many clients find the provisions of an interpreter that assists them in communicating their needs as being helpful and an empowering experience (Loewenthal et al., 2010; Barron et al., 2010). Consequently, the need for bilingual language interpreters is evident to ensure that non-fluency in English does not prevent access to psychological services. There are also issues pertaining to professionalism. Participants in this study were all registered to a professional body and are required to hold certain recognised qualification and meet certain ethical code of practice; such professional status guards the interest of practitioners but also the general public and is important when considering clinical confidentiality. What professional obligations are practitioners required to uphold with clients who require the support of an interpreter and what are the professional obligations of interpreters in relation to client confidentiality. In particular, confidentiality can be a problem in cases whereby the client and the interpreter come from the same local ethnic community and might share similar community events or ceremonies. Furthermore, what does it mean for the professional practitioner to offer

therapy with the aid of an interpreter who may not hold any clinical qualification to practice therapy- does this undermine the clinical practice of psychology. Finally, if the views of the practitioners, in this study, supports the argument that on-going psychotherapy with the help of an interpreter is not beneficial for clients (Perez-Foster, 1998) what could be the implication of such findings both for professional interpreters working in the mental health field but also for clients that require the aid of an interpreter to communicate their concerns and in accessing services. These are important issues that are worth considering as the purpose of this study is not to disadvantage any group in society but rather to offer some insight into this area of clinical work.

3.3.6 The Participants

A total of eleven psychological practitioners volunteered to take part in this study. This sample size is in keeping with other qualitative research in this area (Raval & Smith, 2003; Bassey & Melliush, 2012; Selkirk, Quayle, & Rothwell, 2012). Furthermore in their social constructionist grounded theory study into the experiences of families of critically ill patients, Plakas, Cant, and Taket (2009) show that although they collected data from twenty-five patient relatives, from interview number thirteen it was considered that the data had reached saturation.

All the participants worked at the IAPT services. All five of the IAPT service teams were represented since there was at least one participant from each team. The participants were all qualified adult mental health professionals drawn from the professions of counselling psychology, clinical psychology, and psychotherapy. The mean number of years of clinical experience since qualifying in their core profession was nine years; the mean number of years that participants had worked with an interpreter was seven years. Nine of the

participants were female and two participants were male. Participants' age ranged between 31-60 years. Participants were from different ethnic heritage, including white-British, white European, African, and white non-European, reflecting a culturally heterogeneous group of participants. Five of the participants were bilingual but they only offered therapy in English within the context of the IAPT services. Participants reported at least one clinical area of interest, ranging from adult survivors of childhood sexual abuse, trauma related panic disorders, depression, anxiety disorders, and bereavement work.

3.3.7 Table illustrating demographic details of participants

The table below presents demographic details of the eleven participants.

Participant	Gender	Bilingual therapist	Name of registered governing body	Primary modality of clinical practice	Post-qualification clinical experience (in years)	Experience of working with interpreters (in years)
Sebastian	Male	No	BACP	Person-centred	7	4
Sophia	Female	Yes	BPS; HPC; BABCP	Integrative	2	2
Ruby	Female	No	BABCP	CBT	2.5	2
Joshua	Male	No	BABCP	CBT	3.5	3
Participant	Gender	Bilingual therapist	Name of registered governing body	Primary modality of clinical practice	Post-qualification clinical experience (in years)	Experience of working with interpreters (in years)

Alex	Female	No	BABCP	CBT	3.5	3.5
Naomi	Female	Yes	BPS; BABCP	Integrative	12	8
Mia	Female	Yes	BPS; HPC; BABCP	Integrative	10	10
Helen	Female	Yes	BPS; HPC; BABCP	Integrative	25	10
Emily	Female	No	BACP	Psychodynamic	11	11
Sara	Female	No	BACP	Psychodynamic	14	10
Tamara	Female	Yes	BPS	CBT	8	8

3.3.8 The Researcher attributes

I am a female counselling psychologist in training, who is of middle class Turkish origin and am bilingual.

Whilst my mother tongue is mostly used when I am back in Turkey and communicating with my parents, I predominantly use English in my work, social and daily life. At the start

of my training I made a conscious choice to offer therapy in my mother tongue, to people who were not receiving therapeutic support because they have limited spoken English. In my clinical placement I was faced with the challenging task of how to apply my theoretical knowledge to my clinical experience of working in a different language. Over time my interest into how therapists experienced the therapeutic situation when working with an interpreter grew. Thus I wanted to examine and better understand the structural elements of how the clinical context of a triad is socially constructed, by its members, and used as a platform to offer therapy.

The current shortage of therapists from different ethnic backgrounds who are able and willing to work with clients with limited spoken English is such that the waiting list formed of this client group is huge. Consequently, given my ability to work with a certain ethnic group I was initially not offered the chance to work with interpreters myself within the voluntary and NHS services that I volunteered at. However as the need to conduct this study became evermore apparent, I decided for reasons of wanting to maintain a level of 'researcher neutrality', that it was best not to engage in clinical work that required the assistance of an interpreter. The experience I had gained from my clinical placements placed me in a good position to understand the potential challenges that this area of therapeutic work could present. At the same time, because I had no prior experience of working within the set up of a triad I could separate my experience from that of the participant and thus maintain a degree of neutrality when analysing the data from the research interviews.

3.3.9 The Interview Schedule and Interview

All the participants were interviewed in their usual clinical work place. This was either a therapy room within a primary care NHS surgery or at one of the IAPT regional offices where the teams were based.

A semi-structured, qualitative interview schedule with a few broad open-ended questions was devised for this study (see appendix IV). The open-ended nature of an intensive interview fits grounded theory method particularly well. The combination of flexibility and control inherent in semi-structured interviewing allowed the researcher to initiate a direct yet open-ended, in-depth conversation with the participant to explore an aspect of life about which the participant has substantial relevant experience to shed light on (Charmaz, 2006).

To begin with details regarding the nature of the interview, issues of confidentiality and the participant's right to withdraw from the study at any point of their choosing, were explained. This information was also given in a written format as part of the consent form which the participant was asked to sign (see appendix III). Some demographic information was collected before the digital voice recorder was switched on and the interview began. To encourage participants to talk freely about the areas of interest for this study, the semi-structured interview schedule consisted of four main questions namely;

- 1) Can you please tell me your experience of providing individual therapy to clients with limited spoken English with the aid of a bilingual interpreter?

This question was aimed to help ease any anxieties the participants may have had about the interview by allowing them to talk freely about something that was familiar and personal to them. As an opening question it also set the context of the research interview as the

question clearly highlights the key interests of the study with the message that the focus is on practitioners' personal experience of working with interpreters in clinical practice.

Through questions such as 'can you tell me more'; practitioners were encouraged to link their experience with their thoughts and feelings about working with interpreters.

Consequently, this open-ended, non-threatening and non-judgemental question produced rich data as practitioners were willing to talk about an area of their clinical experience that often received little attention.

- 2) In what way, if at all, does working with a bilingual interpreter influence your clinical practice?

This question prompted participants to elaborate further on specific areas of the triadic work. By asking further questions such as 'could you open that up a little; in what way exactly' participants were encouraged to consider the clinical implications of working in the triad with the interpreter. Participants spoke of both the rewarding aspects of this work as well as the drawbacks, and often gave explicit examples from their clinical experience. The purpose of this question was also to produce data that would allow a deeper exploration of how working with an interpreter could benefit clinical practice whilst also acknowledging the shortfalls of this work and using these to highlight areas of clinical practice, that requires further attention in advancing professional and service development.

- 3) Can you tell me about the type of training you have received either prior to working with a bilingual interpreter or following your experience of working in this way?

The main purpose of this question was to allow participants to reflect on how their training has potentially enabled them to practice within the triadic style of therapy. Both the BPS

and the IAPT training criteria's require trainees to demonstrate competence in working with clients from different socio-cultural backgrounds and for training courses to cover areas of cultural sensitivity for clinical practice. Furthermore the BPS division of counselling psychology professional practice guidelines suggest that training in working with interpreters should be part of the core training or else constitute part of continued professional development. Likewise, in accordance with equal opportunity protocols the government framework for IAPT services recommends that where necessary, commissioners may need to consider funding training on working with interpreters. This question produced a large volume of data indicating the extent to which this area of professional development is neglected and enabled the research to examine the potential implications of this for practitioners working with interpreters, and the mental health service being offered to clients.

4) Could you tell me a little about the sitting arrangement of the client, the interpreter and yourself?

Although initially this question did not form part of the interview schedule during the process of data analysis and particularly through theoretical sampling, it appeared that participants spoke of the sitting arrangement without being prompted to, and more importantly it seemed that the sitting arrangement held a symbolic meaning to how the practitioner conceptualised the role of the interpreter. This question was therefore included in later interviews.

Due to its flexible nature the interview schedule varied between individual interviews, thereby allowing particular themes that emerged to be taken up.

The interview finished when all questions were asked and the discussion came to a natural end, usually lasting an hour. The participant was asked to read and sign the debriefing document (see appendix V). The researcher explained how the data collected will be handled and that it will be destroyed after 5 years. If participants were in agreement with the information offered they were requested to sign a participant confirmation of handling sheet (see appendix VI). The interview content was transcribed and subjected to a grounded theory analysis.

3.4 Analytical Procedure and Data Analysis

Various different procedural guidelines for carrying out a grounded theory analysis exist. Some authors have argued that codes, categories and themes should emerge freely from the data (Charmaz, 2006; Heath & Cowley, 2004). Others, including Strauss & Corbin (1998) suggest using a ‘coding paradigm’ such as the process of ‘axial coding’ whereby data fragments are put together and constantly compared at the level of how it relates (or not) to subsequent data. It is suggested that axial coding is conceptual rather than descriptive and offers a greater explication of the process (McCreaddie & Payne, 2010). In Glaser’s (1978) version of grounded theory, during the process of theoretical coding the researcher is required to consider the six categories which constitute his eighteen ‘coding families’ including; causes, context, contingencies, consequences, covariances, and conditions. Charmaz’s (2001) constructionist grounded theory method proffers a two stage approach of initial and focused coding, and makes a commitment to memo-writing, constant comparison and theoretical sampling, whilst also recognising that conceptual categories “*reflect the interaction between the observer and observed*” (Charmaz, 2001, p.337). From a constructionist, interpretative perspective the grounded theory researcher aims to study the research participants’ intentions, actions and meanings. The guidelines involve the

process of initial and focused coding which helps the researcher develop categories, whilst writing memos leading to theoretical sampling which helps fill out categories and develop theoretical coding to synthesis categories and offer a framework to understand the social phenomenon explored. Reflexivity on the part of the researcher is incorporated through the use of memos, a method of noting down personal thoughts and influences, which are later made use of as part of theory building.

According to Charmaz (2001) as a starting point the researcher should aim to use “*their background assumption, proclivities and interests to sensitize them to look for certain issues and processes in the data* [asking the first question] *what is happening here?*” (p.337). McCreaddie and Payne (2010) explain that theoretical sensitivity addresses the role of the researcher because it infers to the researchers ability to give insight and meaning to data. For example, in carrying out this study an area of interest was how practitioners worked with interpreters, this involved considering practitioners’ perception of the interpreter and how they conceptualised the interpreter’s role within the group process of the triad this interest helped the researcher to look out for descriptive terms, such as ‘mouthpiece’ or ‘translation machine’; thus sensitising the researcher in the process of analysing the data. However, Charmaz (2001) also encourages the researcher to use such guiding interest as “*departure points for developing, rather than limiting, (their) ideas*” (p.337). Therefore by remaining open to perusing unanticipated leads in the analysis of the data, the researcher was able to explore the notion of professionalism and its influence on how participants’ perceived the role of the interpreter within the triadic group as well as considering how wider social concepts of professionalism and the medical context of the NHS potentially influenced practitioners’ experience of working in the clinical context of a triad.

In the process of data analysis the researcher held in mind the question of “*What is happening here*” (Charmaz, 2001, p.337) thus focusing on what participants were doing and making note of these, in the form of ‘actions and processes’ (Charmaz, 2006, p.69), in the margins of the transcript. According to Charmaz (2001) the process of examining what people are doing can lead to “*understanding multiple layers of meanings of their actions. These layers could include the person’s (1) stated explanations of his or her action, (2) unstated assumptions about it, (3) intentions for engaging in it, as well as (4) its effects on others and (5) consequences for further individual action in relation to personal relations*” (Charmaz, 2001, p.339). Therefore by looking at actions in relation to implicit meanings, intentions and taken-for-granted concerns it was possible “*to obtain tick descriptions and to develop categories*” (Charmaz, 2001, p.339). In keeping with Charmaz (2001) view that “*the interaction between the research and the researched ‘produces’ the data*” (p.339) the data was analysed in terms of the social and individual constructions entrenched in the dialogue. Indeed, according to Charmaz (2001) because the data is the (co)constructed product of the researcher and the participant so too are “*the meanings that the researcher observes and defines*” (Charmaz, 2001, p.339). Thus, the interactive influence of the researcher is acknowledged throughout the data analysis as it is in the process of collecting the data.

In the sections that follow the procedure taken in the data analysis of the interview transcripts are described, first a brief narrative of the process of the research is offered, followed by a more detailed account of each phase of the data analysis. These reflect the principles of constructionist grounded theory method as proposed by Charmaz (2006) and, to a greater or lesser extent, are evident in other grounded theory research as exemplified in

the work of Plakas, Cant, and Taket (2009); McCreaddie and Payne, (2012) and Thomson, Petty, and Moore, (2014).

3.4.1 A Brief narrative of the process of the research

Interviews were transcribed and analysed using the social constructionist grounded theory as outlined by Charmaz (2006). In the first instance data analysis involved going through transcripts line-by-line, looking for what is happening in the data in terms of actions and process and identifying similarities and differences both within interviews and between accounts. Through this constant comparative method initial codes that stick closely to the data and reflect actions were formed. These initial codes were provisional and helped in identifying potential themes that were worthy of further exploration (Charmaz, 2006; Selkirk, Quayle, and Rothwell, 2012). The most frequently occurring codes at this initial stage were used to develop focus codes, which are more selective and conceptual than initial codes and have theoretical significance in accounting for large segments of data. Consequently, focus codes were used to sort through large amounts of data. Focus codes that appeared to hold the greatest analytical value in categorising large data were retained. The final stage of data analysis involved developing theoretical codes that aim to integrate categories formed through focus codes and specifies relationships between them. The most prominent and meaningful categories that held exploratory power were raised to the level of theoretical concepts making it possible to construct a feasible model which explains the relationship between the main categories, and their relation to the core category, thus offering a coherent analytical story of the data. Throughout the data collection and its analysis detailed memos in the form of analytical thoughts and decisions were kept and used to assist in the various stages of data analysis. Furthermore the initial phases of data analysis coincided with theoretical sampling. This involved returning back to the field to

obtain relevant data to further check, qualify and elaborate the boundaries of the categories and to specify the relations between categories.

3.4.2 Initial Coding

Charmaz (2001) describes coding as “*the process of defining what the data are all about*” (p.341) therefore coding acts as a stepping stone between gathering data and developing a working hypothesis to explain the collected data. The purpose of the initial coding stage of data analysis is “*to break the data into categories and begin to see processes*” (Charmaz, 2001, p.343). This involves reading each individual transcript and initially looking for, and identifying what is happening in the data. At this beginning stage the data is studied in light of the process and action questions highlighted by Charmaz (2001) which include: “(1) *What is going on here?*, (2) *What are people doing?*, (3) *What is the person saying?*, (4) *What do these actions and statements take for granted?*, (5) *How do structure and context serve to support, maintain, impede or change these actions and statement?*” (p.342).

Charmaz (2001) claims that line-by-line coding prevents the researcher from becoming so immersed in the participants categories and worldview and helps promote critical analytic work by asking questions about the data such as: “(1) *What process is at issue here?*, (2) *Under which conditions does this process develop?*, (3) *How does the research participant(s) think, feel, and act while involved in this process?*, (4) *When, Why and how does the process change?*, (5) *What are the consequence of the process?*” (Charmaz, 2001, pp.343-344). The analytical process of initial coding led the researcher to notice the ways in which participants conceptualise the role of the interpreter and how this is reflected in the categories participants use to describe the interpreter. For instance, the word ‘used’ in the statement ‘when I first *used* interpreters’ reflected the participant’s view of the interpreter’s role as being like a machine, in contrast, when participants spoke of an

interpreter in a positive light the word ‘*use*’ tended to be replaced with the word ‘*work with* an interpreter’ indicating a co-worker relationship. It was interesting for the researcher to observe at what points the participant(s) would swap between a human vs. non-human description of the interpreter.

3.4.3 Focused Coding

The process of focused coding aims to “*synthesize and explain large segments of data*” (Charmaz, 2006, p.57), this stage involves using earlier codes that continuously reappear in the initial coding phase of data analysis to sort through large amounts of data.

Consequently, focused coding “*is less open-ended...considerably more selective and more conceptual*” than initial coding (Charmaz, 2001, p.344). Although moving from initial coding to focused coding is not entirely a linear process, by this stage the researcher identifies a number of interesting codes that make analytical sense and could be used to apply to large amounts of data. Therefore focused coding is a phrase chosen to represent a group of initial codes, and sometimes this was the same as the name of an initial code itself: an ‘in vivo’ code (Charmaz, 2006). These in vivo codes were preferable as they stayed closer to the data; an example would be ‘the interpreter perceived as an impediment to clinical work’.

3.4.4 Theoretical Coding

Theoretical coding aims to offer an explanation for the relationship between categories created through focused coding. Therefore, theoretical coding brings about a coherent analytic story of the data (Charmaz, 2006). Charmaz (2001) proposes keeping focused codes brief and active so that process in terms of what is happening can be seen more

readily and this also helps to view them as potential categories. According to Chramaz (2001) *“by raising a code to the level of a category, you [the researcher] treat it more conceptually and analytically. Thus, you begin (1) to explicate its properties, (2) to specify conditions under which it arises, is maintained and changes, (3) to describe its consequences and (4) to show how this category relates to other categories”* (p.345). In accordance with this a category is part of the researcher’s analytical framework in developing a working theory of the data. Through categorising, the researcher selected a limited number of codes that had overriding importance in explaining events or processes in the data; in this way a category subsumes themes representative of several codes. Whilst some categories represented the researcher’s *“theoretical or substantive definition of what is happening in the data”* (Charmaz, 2001, p.345) others were ‘in vivo’ codes that were taken directly from participants’ interview, for instance the ‘triangular seating arrangement’. Overall, the process of focused coding helped the researcher to develop categories through the constant comparison of data and concepts. This involves comparing data between participants, comparing data from the same participant but at different points during the interview and comparing categories in the data with other categories (Charmaz, 2001).

Often the ‘categories’ that are developed from this stage of data analysis integrate around a core category (Heath & Cowley, 2004; Charmaz, 2006). In the present study two main categories, which subsumed all of the focused codes and sub-categories, were formed. A core category was then constructed to bring these two main categories into a theoretical model.

3.4.5 Theoretical Sampling

The purpose of theoretical sampling is to obtain pertinent data to further “*check, qualify, and elaborate the boundaries of [the] categories, and to specify the relations among categories*” (Charmaz, 2006, p.107). Theoretical sampling therefore helps to clarify and refine the properties of the categories, contributing towards the theoretical development of the data (Charmaz, 2006).

An area of interest that arose as a result of the data analysis was the symbolic meaning participants were attributing to the seating arrangement within the triad. It appeared that the seating arrangement reflected the participant’s thoughts about the interpreter’s membership status within the triad. In order to gain greater depth and understanding, the researcher took this idea back to the field. In later interviews the researcher listened to see if participants would discuss the seating arrangement independently, prompting them on the subject if not. In this way the interview schedule developed and became a natural part of the process of eliciting further useful information about the way participants worked.

The theme of the interpreter as being perceived as an ‘impediment’ or an ‘asset’ to the therapeutic process was also driven by what previous participants had raised during the interview. It seemed that when participants viewed the contributions of the interpreter as being valuable to the therapeutic work, the interpreter was perceived as being an equal member of the triad and this dictated the seating arrangement. In these cases the members of the triad sat in a triangular shape each having equal distance to one another and facing a centre point. This sitting arrangement differed to those incidents where the interpreter was asked to sit slightly apart so to be out of eye sight perhaps indicative of them not being considered a full member of the triad and their input as not being of significant value to the therapeutic process. Therefore, the symbolic meaning of the seating arrangement was a

good demonstration of how important the role of the interpreter was considered to be by the participant and their willingness to negotiate the distribution of power between the members.

By performing purposeful theoretical sampling from the data and sample in this way, the researcher was able to delineate and tighten the conceptual categories. This facilitated the development of theory that offered a better representation of the relationship between the categories.

3.4.6 Memo-Writing & Theoretical sorting

Charmaz (2006) states that conceptual memo-writing leads directly to theoretical sampling because it encourages making early comparative analysis of data and codes, moving upwards towards theoretical categorising. The researcher kept successive memos throughout the research process. The memos were in the form of informal analytical notes of the researcher's thoughts and inferences arising from comparative analytic work. In this way memos served to identify gaps in categories, highlighting areas where theoretical sampling would be helpful for filling out categories. The process of writing memos was later inter-related to that of sorting, diagramming, and integrating the codes and categories progressing towards theoretical development of the data. In all, the process of gathering data, coding and developing categories is connected to the process of memo-writing.

Charmaz (2001) suggests that the process of memo-writing goes beyond the purpose of sorting data into topics, through memo-writing the researcher considers codes as processes to explore and identify how various categories are connected in an overall process. Thus, from early on, memo-writing helped the researcher to direct and shape the data analysis.

3.4.7 Theoretical Saturation

In grounded theory, the principle of ‘theoretical saturation’ signifies that the researcher can stop collecting data because “*gathering fresh data no longer sparks new theoretical insights, nor reveals new properties of the core theoretical categories*” (Charmaz, 2006, p.113). Although it is suggested that grounded theorists should aim for theoretical saturation because of time and resource limitation theoretical saturation was not a principle endorsed by this researcher. From a social constructionist perspective it could be argued that given the numerous ways of viewing or explaining a particular phenomenon reaching theoretical saturation might not be achievable in any research (Burr, 2003). In this study, it was not possible for the researcher to ascertain when the maximum number of viewpoints had been reached. Consequently, data analysis ceased when the researcher had reached sufficient depth in each category to form a coherent construction of the meaning of the available material, this meant that a total of eleven research participants were interviewed for this study, the limitation of this small sample is discussed in chapter 5.

3.4.8 Example Matrix

The examples of the coding process that show the different levels of abstraction from the raw data are given below. These illustrate how the categories were drawn from the raw data. In the far right column, excerpts from the raw interview text are given. The initial codes arrived by the researcher from this text are shown in the next column to the left. The larger focused codes, which incorporated two or more of the initial codes is shown in the next column to the left. These were collapsed into categories so to condense the data for the formation of a theoretical concept as demonstrated in the far left column. Overall, these demonstrate that the researcher’s interpretations and abstractions are grounded in the data

(Charmaz, 2006). Further examples are provided both in relation to each of the core categories and in the appendix (see Appendix IX).

SUB-CATEGORY	FOCUS CODE	INITIAL CODE	RAW DATA
De-humanising the Interpreter	<p>The role of the interpreter is dehumanised</p> <p>Attempting to minimise the personal influence or presence of the interpreter</p>	<p>‘used’ interpreters rather than worked with interpreters.</p> <p>‘To be my voice’ rather than be considered as a professional in their own right</p> <p>The role of the interpreter to be the voice of the practitioner.</p>	<p><i>‘When I had first ever used interpreters’.</i></p> <p><i>‘They’re there to be my voice’.</i></p> <p><i>‘Their role is.. they’re to be my voice, in a way, and it’s not for them to add or omit anything I’m saying’.</i></p>
Professionalism	<p>Feeling deskilled and questioning ones professionalism</p> <p>The possible role reversal between the actors of the triad from a position of professionalism, a sense of being the</p>	<p>As a therapist it feels weird not to understand what’s going on</p> <p>Professionalism and normality. A certain way of being that suggests professionalism</p>	<p><i>‘It’s very weird to not be understanding what’s going on when you’re wanting to be a therapist’.</i></p> <p><i>‘I mean, I’ve sometimes felt unprofessional when it doesn’t go well, you know, if you’re really not, you’re not able to run a normal session if you like, one’s left feeling, well, that’s, you know, going</i></p>

	'expert' or feeling 'skilled' to not understanding, feeling unprofessional and de-skilled	The therapists concerns regarding the effectiveness of the therapeutic triad- associated with feeling deskilled	<i>backwards'.</i> <i>'I suppose maybe a little bit more in the earlier days of, you know, sometimes feeling relatively de- skilled, when it's not going well'</i>
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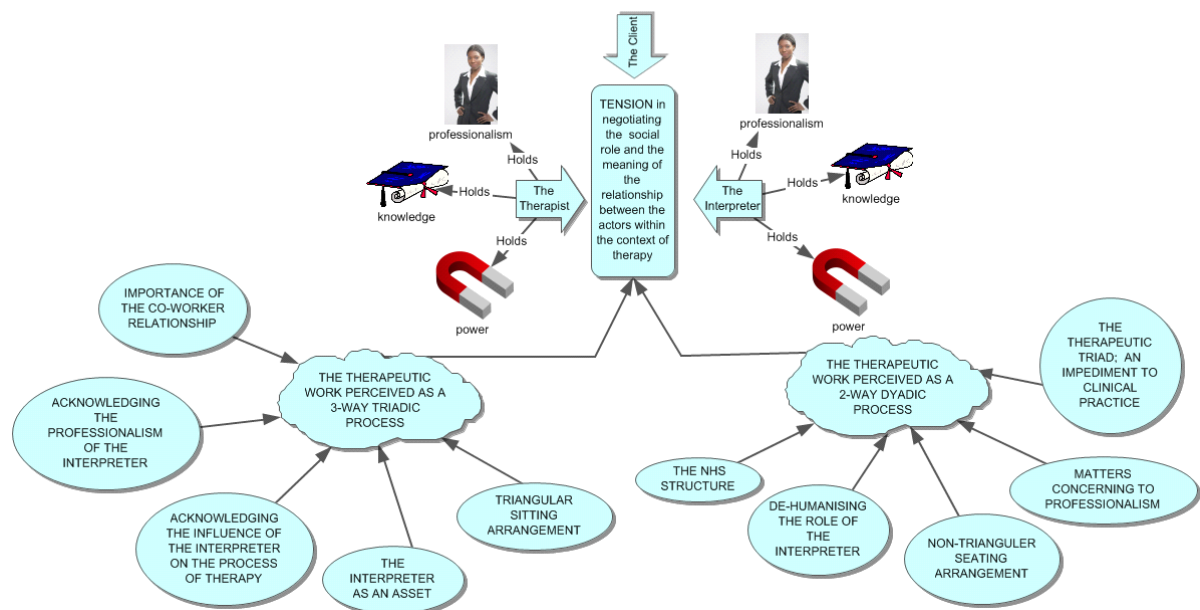
This chapter addressed the methodological standpoint the researcher employed in this study and the method by which the research was implemented. The researcher has indicated those areas that have deviated from Charmaz's (2001, 2006) description of social constructionist grounded theory. The following chapter presents the findings of the analysis described above.

CHAPTER 4: RESULTS

This chapter illustrates how the social constructionist grounded theory method (Charmaz, 2006) has been used to create a theory about the position the therapist takes up when working with an interpreter in the clinical context of a triad. Following the initial, focused and theoretical coding methods, one core category and two main subcategories were constructed. These categories were then organised to create a theoretical model, which from a social constructionist and symbolic interactionist perspective brought the findings together into a meaningful construct. The findings are first presented as a grounded theory model and then in relation to the two main categories, including the various sub-categories that formed them. This is followed by the core category which completes the grounded theory model. The categories and their theoretical relationships are presented with many detailed raw interview data, this is in keeping with Charmaz's (2001) preference so to; *"keep the human story in the forefront of the reader's mind and to make the conceptual analysis more accessible to a wider audience"* (Charmaz, 2001, p. 351).

4.1 Diagrammatic Representation of the Findings

The following diagram illustrates the theoretical model. It shows how the subcategories and categories are considered as being in relation to each other as well as to the core category. The three members of the triad are represented by the arrows at the top of the diagram along with the perceived social attributes of the practitioner and the interpreter. In the centre of these arrows is the core category, with the two main categories illustrated by the two clouds on either side of the diagram. The sub-categories (as illustrated by the circles) filter into the two main categories (See appendix VIII for a full illustration of the diagrammatic representation of the findings presented here).



4.2 An Overview of the Findings: A Grounded Theory

The therapeutic approaches employed in mental health work are largely based on the exclusive relationship between the therapist and the client. The presence of an interpreter immediately changes the nature of this relationship. The introduction of this additional member requires each person's role and position within the clinical context to be renegotiated. As the nature of the therapeutic set up changes from a dyadic to a triadic form, the participants, in this study, seemed to struggle to establish their position in a context that becomes somewhat unfamiliar. Faced with this situation, the participants seem to oscillate between continuing to perceive the therapeutic relationship as a two-way dyadic process (main category 1); and accepting the therapeutic relationship as a three-way triadic process (main category 2). Whereas in the first instance the interpreter is denied affiliation to the clinical work, in the second situation the interpreter is perceived as a valuable member of the team. Although the latter of the two options appears to be more

desirable it has its drawbacks. Importantly, given that most models of therapy take a dyadic perspective to clinical work their application to a triadic practice becomes difficult. For example the concept of transference and counter-transference becomes ever more complex, when considering who is at the receiving end of whose transference. Furthermore, the triad requires the therapist to renegotiate his or her position as the expert and thus the person in charge of the therapeutic process. It demands addressing issues of professionalism and related to this is the issue of power in the context of clinical work which has traditionally been unquestionably appointed to the therapist. Overall there appears to be tension in this area of clinical practice (core category) as the interview data suggests that participants struggle between these two different positions of how to meaningfully work with an interpreter within the clinical practice of a triad.

4.3 Main category 1: The therapeutic relationship perceived as a 2-way dyadic Process.

All the participants made reference to the many challenges of having to work with an interpreter. There seemed to be a number of factors which made the transition of clinical practice from a dyadic to a triadic process difficult. Firstly, there were several practical issues such as the average length of a session with an interpreter exceeded those without an interpreter. The limited availability of interpreters and their time meant that consistency from one session to the next was difficult to maintain. Participants raised concerns about the possible impact of changing interpreters during the course of therapy, drawing particular attention to the general idea that therapeutic consistency provides a safe and secure space for the client. Furthermore, the lack of consistency seemed to hinder the potential for the therapist and the interpreter to build a co-worker relationship. Participants also expressed concerns around issues of trust and control when working with interpreters.

This was particularly so in relation to the accuracy of the translation being offered and the level of client confidentiality that is possible within the clinical practice of a triad. In addition the serious lack of training participants received in this area, both during and after their initial professional training appeared to increase the uncertainties and the apparent role ambiguity participants experienced in the process of the clinical practice of a triad.

4.3.1 Example Matrix for main category 1: The therapeutic relationship perceived as a 2-way dyadic process.

The example matrix below demonstrates how the sub-categories, focus codes and initial codes were developed from the primary interview data (please refer to Appendix XV for a more in-depth version).

SUB-CATEGORY	FOCUS CODE	INITIAL CODE	RAW DATA
The triad –An impediment to clinical practice	Practitioners reluctance and discomfort of having to work with interpreters	Working through an interpreter is an impediment, slowing things down Reaching a point of never being comfortable about working with an interpreter	<i>Working with interpreters for me, it's definitely an impediment and it slows things down. I'm never comfortable, is, I guess is what I would say I am now, never comfortable with working through an interpreter, if that makes sense.</i>
Difficult to establish a therapeutic alliance with the client	A need to hold onto the 'ideal' dyadic relationship	The structure of the triad doesn't fit well with the traditional idea of building therapeutic relationship	<i>It's never going to be the same as when it's just two people in the room.</i>

SUB-CATEGORY	FOCUS CODE	INITIAL CODE	RAW DATA
Loss of immediacy	The structure of the triad loss of; -Language -Immediacy -Authenticity	<p>Concerns and anxiety about managing the three-way process</p> <p>The slow pace of the triad means that the immediacy of the therapeutic process is lost</p> <p>The process of translation creates too much thinking space thus the process doesn't feel authentic</p> <p>Keeping it basic, working at the surface level</p>	<p><i>So having a third person there, I feel, is making it more difficult to establish an effective therapeutic relationship. I was quite curious as to how I would manage that sort of three-way process. I was also, I suppose, anxious as to how it would go, how it would affect the establishing of the relationship.</i></p> <p><i>It slows the process of working with somebody down, because the immediacy is taken away. You think what you're going to say next and then say it. And I think when you do that, it tends to lose its authenticity.</i></p> <p><i>I sometimes feel it can be more difficult to go into the more complex concepts.... So I might, at times, just make it more about the basics.....</i></p>

SUB-CATEGORY	FOCUS CODE	INITIAL CODE	RAW DATA
Implication of the process of translation on the process of therapy	<p>The triad feels restrictive, limiting, not able to work at a deeper level</p> <p>Assuming that the structure of the triad works better with certain modalities- The grass is greener on the other side.</p>	<p>Triad restrictive to simple, basic therapeutic work difficult to cover more complicated material</p> <p>The structure of CBT makes it difficult to translate into other languages. What does this say about the language from which therapy is constructed?</p>	<p><i>and keep it more to a sort of five areas model, which is perhaps more surface level, than going into the more kind of in-depth work.</i></p> <p><i>I think I still feel restricted though, in terms of what I'm able to do, because I feel I probably have to keep it quite simple for it to pass through translation. CBT is, it's very structured, and almost like quite formulaic. It's quite difficult to pass that through translation as well, so I guess there are a lot of obstacles, whereas you wouldn't get that in other disciplines, you know, in counselling or psychodynamic.</i></p>
The interpreter selecting how information is conveyed on the ground of personal preferences	<p>The interpreter Filtering information on grounds of personal conclusions or assumptions before offering its interpretation</p>	<p>Not being transparent about possible existing cultural barriers</p>	<p><i>Cultural issues can get in the way, like a male interpreter and a female client, and they [interpreters] don't always make that clear to me as a practitioner.</i></p>

SUB-CATEGORY	FOCUS CODE	INITIAL CODE	RAW DATA
The NHS culture and its implications to the clinical triad	Not feeling supported or valued	<p>The personal assumptions and experience of the interpreter influencing their interpretation of the clients material</p> <p>Feeling isolated, not supported</p>	<p><i>Something can be said and they will kind of filter it before they repeat it back to me, for various reasons. It might be because they don't... they might be embarrassed about it themselves, about saying it; they may feel that what the client is saying is rude. I mean, I've had that. And they might also think that I would be embarrassed by what is being said.</i></p> <p><i>When I started working I just felt like we had to manage but I wasn't coming from any informed position.</i></p>

SUB-CATEGORY	FOCUS CODE	INITIAL CODE	RAW DATA
De-humanising the interpreter in an effort to stay in control and abate anxiety	The challenge of balancing NHS service demands and those of the triad	The demands of the NHS doesn't accommodate for working in the slow pace of the triad	<p><i>It's about reducing patient numbers, about working quickly, and as efficiently as possible, and you know, that's the reality of the NHS. ..Often, you will run into more dead ends and more problems.., that sort of clashes with performance indicators and things, you know, that you're meant to go through a certain, you know, number of sessions with the client, so you, in a sense, can't slow down, even though you need to slow down.</i></p>
	Interpreter Vs. Translator or Machine Vs. Person	Wishing that the interpreter was a universal translating machine.	<p><i>I'm really quite strong even now about the difference between a translator and an interpreter and what I want is a translator, but what I get is an interpreter I want my translator.... I want them to be a universal translating system.</i></p>

SUB-CATEGORY	FOCUS CODE	INITIAL CODE	RAW DATA
The symbolic non-triangular sitting arrangement	Wanting to keep the dyad through the sitting arrangement	<p>Dyadic feel to a triadic set up-the elephant in the room</p> <p>Triangular sitting arrangement feel like the interpreter is part of the dynamics of the therapy</p>	<p><i>Sometimes, it might be about asking them to sit further back, so they're not in the eye line of the client or me...if possible, sometimes to sort of be sort of separate from, so there's kind of a sense of it's just the client and myself.</i></p> <p><i>What I'd prefer is if the interpreter is sitting just slightly behind the client and looking at me so that...if they're sitting in the middle then it's that triangular arrangement, in which the interpreter is part of the dynamics of the therapy.</i></p>

4.3.2 The therapeutic triad: An impediment to clinical practice

As an initial introduction to the interview, participants were invited to speak of their general experience of offering therapy in the clinical context of a triad. All of the participants spoke of their experiences in terms of the difference in the therapeutic process of the triad to that of the more common dyadic style of therapy.

Sebastian, whose clinical practice is fundamentally based on the person-centred model of therapy, comments:

It's [the therapeutic triad] not going to be as therapeutic as it can be..., Working with interpreters for me, it's definitely an impediment and it slows things down... It slows the process of working with somebody down, because the immediacy is taken away.

Sebastian's comment that he considers working with interpreters as being an 'impediment' to his practice seemed to sum up most of the comments made by participants regarding the shortcomings of the therapeutic triad. As a result this became a key sub-category. It seemed that the therapeutic triad presented certain barriers which the participants attempted to avoid addressing, by continuing to perceive the therapeutic relationship as a two-way dyadic process (main category 1).

One such barrier of working with an interpreter involves the process of interpretation. The full content and understanding of what the client has said is lost to the therapist, who has to work with the summarised content offered by the interpreter. However, this summarised content is possibly influenced by the interpreter's perception and his or her understanding of what the client wants to express.

Working as a cognitive behavioural therapist in the NHS, Alex spoke of her concern regarding the accuracy of the material she receives:

I often worry....about how much of what I'm saying, and what the client is saying, is being passed back and forth effectively. Is it accurate? Is it the same message that we both want to give? Is it being translated in that way?

Sophia, who is a counselling psychologist, acknowledges that unlike her, the interpreter is not trained to be aware of how his or her own discourse can influence the process of therapy:

We're being taught to be non-judgemental, to be ethical, to be open-minded, to watch our eye contact, watch our body language to our clients, to not pass on any judgements, to limit our own countertransference reactions, you know, by sending us to see a therapist when we do our training, there's so much that us therapists have to follow, that you know,

it makes you wonder about the presence of a third person who's not trained to follow any of those things. What kind of impact would that have.

Sebastian also touches on the idea that the client's discourse can be coloured by that of the interpreter's. Sebastian explains that as a therapist he has to try and understand the client's experience through the interpreter's world:

In person-centred terms, that 'as if' moment doesn't really happen because, it's as if I'm in that person's world through an interpreter, so I'm also in the interpreters world, I guess, because it's got to go through them.

Considering that the interpreter is in a position to influence how the information between the two languages is conveyed he or she is consequently in a position to control the course of the therapeutic process. Indeed, many of the participants gave detailed examples of clinical experiences whereby the interpreter's view and preferences not only influenced but also possibly had a serious impact on the clinical work.

Sophia illustrates this point well as she explains:

It's not like a computer doing the translation, dramatically; it's someone else's perception. They receive my intervention or my verbal input, they process it and then they interpret it back to the client, but they don't always interpret or translate everything, it's what they judge, and this is very unconscious.

Sebastian speaks of his experience in which the personal preference of the interpreter was fairly influential in the process of therapy and what was actually translated:

I worked with a male interpreter who just didn't like shows of aggression and he didn't like anger, you know, and so, if bad language was used, then it wasn't passed over to me. What I would see is a client behaving themselves rather than being in therapy because they felt that they were being judged by the interpreter.

Similarly, Mia, a senior counselling psychologist, gives an example of how the interpreter's cultural views on what is considered to be socially appropriate behaviour for women and men can enter and influence the therapeutic work:

Once I was working with I think it was an Iranian young man, who was telling me of his difficulties and at some point I asked a question and the interpreter kept talking, which clearly was much more than what I have said. So I interrupted him and I said I don't understand, you seem to be talking a lot more than what I've said and he turned around and said well, I was telling him that he should be ashamed of himself for complaining in front of a woman. And I was just so stunned.

On the subject of gender, a particular clinical experience described by Helena, who is a clinical psychologist, helps to illustrate how socially assigned and accepted gender roles can either limit or open the space for the client to speak of their experience, she explains:

The interpreter couldn't attend at the very last... at a very short notice, so I spoke with the client on her own 'cause she had already arrived and, you know, I'd already noticed that her English was actually quite good...Even though she was asked several times, are you comfortable with the male interpreter, and she always said yes, I'm comfortable, and I didn't really observe any problems. When I asked her again when he wasn't there, she said that she did find it difficult that, you know, there was a male interpreter, there was a male in the room, and that she had been holding back to talk about some of her physical problems which were affecting her sexuality and her sexual life. She found it difficult. So on the basis of that, we decided to continue the sessions without the interpreter.

The examples given by participants indicate that in any given social structure (situation) the rules of social behaviour, in terms of what is and is not acceptable ways of being are socially constructed. In turn these social rules can be very powerful in determining how people behave in social situations and how they present personal experiences. What is interesting is that this social process of creating meanings of lived experience, which takes place on a macro level, becomes clearly visible in the interaction of the triad. In carrying out the analysis of the data, the researcher came to appreciate how each member's lived experience could potentially enter the process of therapy, influencing 'the circle of verbal interaction' and thus constructing the shared experience of members as they engage in the social process of therapy.

4.3.3 Matters concerning to Professionalism

Most of the participants acknowledged the loss of language and its implication. In particular, participants spoke of feeling left out of the dialogue indicating a possible loss of control.

Sara, who is a senior psychodynamic therapist, explains:

You ask a question to the client, and then the client has this conversation with the interpreter that goes on and on and on, and you're wondering, what on earth is going on here, and at the end of it all, the interpreter turns and says, you know, she says yes, or something like that. And this happened many, more than quite a few times. So you're actually left out of what's going on.

Ruby a cognitive behavioural therapist whose initial experience of working with interpreters started whilst she was a psychiatric nurse, also notes:

Sometimes you just get that conversation between the interpreter and the client and you're almost kind of left to the side, to say, you know, as in, you're not part of the conversation.

Tamara, a counselling psychologist working in the NHS, makes a similar point:

The client has said something back to them [interpreter], they've gone and said something back. The client says something else, they say something back to the client and I'm then not in that dialogue.

The loss of direct communication with the client seems to tip the equilibrium, and creates a degree of uncertainty which seems to place the participants in a position of not knowing.

Mia speaks about the anxiety that gets created when she is in a position of not knowing:

It's a bit scary because we don't always know what they're saying.

Sara, who has a lot of experience in working with clients with the help of an interpreter, explains how the loss of language affects her role as the therapist:

It's very weird to not be understanding what's going on when you're wanting to be a therapist.

This comment is particularly interesting because it fits well with the symbolic interactionist position that different social roles require different behavioural styles or ways of being. The implication of this is that, performing the role of the therapist, at least within the context of the traditional dyadic relationship, requires the person to take on the position of the expert. However, the fundamental loss of a common language between the therapist and the client within the triadic context of therapy clearly indicates a certain loss of knowledge, on the part of the therapist. Thus the common social perception of the role of the therapist as the all knowing expert needs to be renegotiated by the members of the triad. It seems that this need to renegotiate roles creates a level of anxiety caused by a shift from a familiar context (therapeutic dyad) to an unfamiliar context (therapeutic triad). All in all, it seems that the lack of familiarity in addition to the role ambiguity possibly left participants feeling uncertain and wanting to reclaim the social throne as the only 'real' professional expert in the context of the therapeutic triad.

As the interview proceeded participants spoke more openly about their anxieties when working with an interpreter. Sara makes an interesting statement of how the presence of the interpreter can make her feel unsettled or 'exposed', as if her practice was being scrutinised or judged by the interpreter:

We're not used to having a third person in the room, so that can feel quite sort of exposing.

Alex recalls feeling anxious prior to working within the clinical practice of a triad:

I was quite curious as to what it would be like, and how I would manage that sort of three-way process. I was also, I suppose, anxious as to how it would go, how it would affect the establishing of the relationship.

Sophia also remembers how she nervously anticipated her initial experience of working with an interpreter:

So before I actually had my first assessment interview with an interpreter, I, I recall being very, very anxious, didn't know what to expect, and lots of different erm, fears, I would say, yes, there was a fear that the presence of the interpreter would impact on the dynamic, that I wouldn't be able to develop a proper therapeutic relationship...., but at the same time, part of me also felt anxious about how I would be received, or be seen by them...I also think, and I must reveal that to you, in counselling psychology, sometimes I feel I'm being judged [by the] interpreter, which I find a little bit uncomfortable.

Similar concerns were also noted by Tamara, who has several years of experience of working with interpreters within the NHS mental health services:

Probably in the beginning, when I had first ever used interpreters, it can be a bit daunting. It's easy to feel oh, there's someone else here, they're going to be judging how I work and they're going to go away thinking oh, why did she say that.

These quotes illustrate how the rules of acting a particular role are socially constructed via the very act of social engagement that takes place between people. Such interactions take place in every possible social situation in which two or more individuals have to interact with one another. The social requirement of the triad is for three people to negotiate and perform the social roles assigned to a therapist, a client and an interpreter, within the context and requirements of a therapy room, which is in itself socially constructed.

More specifically, each person's socially constructed past history affects how they choose to portray themselves within the group. The person's past history also affects his or her expectation of how others need to be, and this in turn affects how the other members chose to portray themselves. The cycle of social construction thus continues to shape not only a person's perception of him or herself, but also those of others in the process of creating social meaning through lived experience.

As a consequence of the anxieties and concerns expressed the question of whether participants had received any training in working with an interpreter prior to offering therapy to a client who did not share the same language as them was raised. None of the participants in this study had received training in this area either during or after their professional qualifications.

Participants spoke of having to learn on the job through a trial and error method which seemed to compound the struggle, anxiety and isolation associated to working in this way.

Sophia states:

The reality is that, no, we haven't been taught, I haven't had any experience or any training on this type of work.

Similarly, Alex explains:

It's a huge discrepancy..... I've not seen any advertised in the time I've been practicing, in terms of how to develop your skills of working with non-English speaking clients, and also, using an interpreter, you know, the skills of getting the most out of a session with that set-up,.....It's just an area I'd really like to know more about. It's like, there seems to be a sense of just learning by doing, rather than learning by example, or learning by training, or learning by professional development. It's a kind of trial and error system.

Mia states:

When I started working I just felt like we had to manage but I wasn't coming from any informed position.

It seems that the lack of training in this area contributes to the tension and anxiety that is inherent in the uncertainty that participants' experience. In an attempt to regain a sense of control in what appears to be an uncertain situation and to abate anxiety it is not surprising that participants chose to continue perceiving the therapeutic triad as a two-way dyadic

relationship (main category 1) as this offers familiarity and with this perhaps a sense of certainty.

4.3.4 The structure of the NHS and related work pressure

Participants also spoke of the demands associated with offering psychological therapy within the resources of the NHS and potentially the implicit pressure this places on their clinical practice, especially when working in the clinical context of the triad.

Joshua explains how the change in organisational demands puts professional pressure on him that is not compatible with the requirements of working in the triadic set up of therapy:

As we're moving towards being outcome based, and there's much more pressure on getting good outcomes, the chances of getting a good outcome are much, much less. And often, you will run into more dead ends and more problems.., that sort of clashes with performance indicators and things, you know, that you're meant to go through a certain, you know, number of sessions with the client, so you, in a sense, can't slow down, even though you need to slow down.

Similarly, Mia explains that often management level expectations of professional performance do not necessarily take account of the clinical demands of working with clients with limited spoken English:

In management meetings when we're saying how certain clinicians are seeing more people than others, you know, I always bring that up and say have you taken into consideration somebody's seeing... It's not the same seeing five patients who are English-speaking and four patients who are non-English on the same day.

Sophia describes how the organisational environment of the clinical work makes it difficult to consider the wider issues of offering therapy with the support of an interpreter.

Unfortunately the need to reduce waiting lists means that the focus and hence most of the resources is spent on matters that are considered to be more important, such as working through cases quickly rather than to attending to the client's need:

There're so much work to be done, there's so much, so many struggles within the politics in themselves that I think we lose the point, we lose the bottom line this is getting lost in translation, the political translation of the NHS. Work is a different world, so it's about reducing patient numbers, about working quickly, and as efficiently as possible, and you know, that's the reality of the NHS, that's so much it can offer anyway, which, what we're talking about seems to me almost like a luxury conversation.

These and other similar statements may explain why so many of the participants expressed frustration due to the slow pace nature of working in the triad. Given the limited resources of the NHS and related to this the pressure to keep waiting lists low, places additional strain on clinical time, making it difficult to allow sufficient time needed to carry out interpreter mediated therapy.

4.3.5 De-humanising the role of the Interpreter: An attempt to reclaim the 'expert' position

Almost all of the participants stressed a need to distinguish between the role of the interpreter and themselves. This seemed to be linked to a need to establish and reclaim their role as the 'true' professional expert in the group. By setting out their expectation of the interpreter, the participants gave a clear message that they are the professional in charge of the social situation and within that the interaction between the group members.

Tamara is clear about what she expects from the interpreter:

I try, in the first instance that I meet the interpreter, if it's someone I've not worked with before, to outline my expectations...I've always outlined what my expectations of them are, and the interpreters that have stuck to that have been the ones that we've been able to go on and work well together...Their role is to be my voice, in a way, and it's not for them to add or omit anything I'm saying.

Similarly, Sophia speaks of her role as being that of a coordinator:

As therapists we are coordinators of the dynamics so we do tend to, at least I do, tend to take a leading role in that.

Sebastian believes it is not for the interpreter to decide what is appropriate or not as this is his role:

It's my role to judge what's going on and it's my role to decide whether a show of aggression or whether bad language is appropriate or inappropriate or whatever.

You're the one that knows, has the techniques, and (laughs) the approaches and, so, you take the lead.

When speaking of the interpreter some of the participants used such terms as, 'That other channel, the other filter'. This has the effect of dehumanising the interpreter, creating the impression that the interpreter is more like a machine and perhaps less important to the therapeutic work than the other two members of the triad. Many of the participants made reference to the role of the interpreter as being the voice between them and the client.

One such example of this was given by Sebastian:

Apparently, in Star Trek, they have this multilingual computer that's in all the Starships and so whatever alien race you are, you sit in a room and a computer would change your voice for you. That's... That's the idea of it, but I just... I want my translator to do that. I want them to be a universal translating system.

Naomi's use of the word 'mouthpiece' also gives a more mechanical nature to the role of the interpreter:

I'm not saying she's not a mouthpiece, just a mouthpiece, and there are other things that she brings, but it's important to have boundaries there, so I'm a strong believer in that.

The above quotations are a good demonstration of how participants struggled to identify the purpose of the role of the interpreter within the clinical context of a triad. Although Naomi states that the interpreter is just a mouthpiece she also acknowledges that this is

perhaps too simplistic in terms of what the interpreter can contribute. In an arguably contradictory sentence she concludes by noting the importance of having role boundaries. Once again the emphasis on having boundaries between the different roles among the members of the triad illustrates how important socially constructed roles are to any social interaction. As the social constructionist and symbolic interactionist suggest the creation of social roles seems to be crucial not only to the development of one's own self concept, but also in knowing the rules of how to act a particular role in the presence of others. This is of course influenced by the perception and social expectation of that particular role by those with whom the person interacts with.

4.3.6 Non-Triangular Seating Arrangement

Although the question of sitting arrangement was not an initial research interest it later became so, as many of the participants chose to speak of how they arranged the sitting position of the client, the interpreter, and themselves when working in a triad. The analysis of the data suggested that the sitting arrangement of the triad was a symbolic representation of the participants' view of the role of the interpreter. More specifically, if the interpreter was perceived as being no more than a channel providing a voice that enabled the participant and the client to understand one another, then the interpreter was sited at a distance, out of sight of the other two members. This arrangement seems to indicate that the interpreter was not fully accepted as an equal member of the triad.

Alex explains that having the interpreter sit further back gives a dyadic feel to what is fundamentally a triadic set up:

sometimes, it might be about asking them [interpreters] to sit further back, so they're not in the eye line of the client or me.....if possible, sometimes to sort of be sort of separate from, so there's kind of a sense of it's just the client and myself.

Emily, who is a psychodynamic therapist, seems to be suggesting that having the interpreter sit behind the client avoids the problem associated with the triangular arrangement, in which the interpreter is part of the dynamics of the therapy:

What I'd prefer is if the interpreter is sitting just slightly behind the client and looking at me so that... If they're sitting in the middle then it's that triangular situation and it feels too much that they're part of the dynamic and they end up having the face to face contact with the client and I prefer to keep the face to face contact myself.

Joshua who is a cognitive behavioural therapist working in the NHS points out that certain schools of therapy make the assumption that the influence of the interpreter is less present in particular seating arrangements.

They're sort of suggesting the interpreter sit just behind the client in psychodynamic, so it doesn't interfere with the, you know, it doesn't block the dynamic between the therapist and the client.

What this demonstrates is the influence that theory has on clinical practice. Indeed it can be argued that it is the power of theory which is traditionally based on the dyadic relationship that partly makes it difficult to apply theory when practicing therapy in the context of a triad.

Overall, what this main category suggests is that therapists struggle to work in the triadic set up of therapy, working with interpreters in offering therapy to clients with limited spoken English. Working within the clinical practice of a triad seems to pose a number of difficulties. Firstly these include practical issues around confidentiality when arranging interpreters from the same ethnic community as that of the client. Furthermore, the pace of the triad is slower therefore extra time is needed to accommodate for the process of translation. Finally, maintaining consistency when trying to book the same interpreter throughout the course of therapy is problematic. However as well as these practical barriers there also seems to be resistance by therapists to fully embrace the triadic practice. Part of

the resistance seems to be linked to professional training where the focus is on learning theory that places high value on the dyadic therapeutic relationship. As a result participants in this study seem reluctant to let go of the dyadic relationship which is familiar and safe. In comparison the triad is unfamiliar and full of uncertainties. These naturally stir up tension and anxiety which the participants attempt to abate by continuing to perceive the therapeutic work as if it was based on a dyadic relationship.

4.4 Main category 2: The therapeutic relationship perceived as a 3-way triadic process.

This main category shows that participants also spoke of this area of their work as being rewarding and that they valued the support of the interpreter. During the course of the interviews all of the participants spoke of how important the role of the interpreter is in making it possible to offer psychological therapy to clients with limited spoken English highlighting how the presence of the interpreter can offer the client a platform to be heard and a space that can be both safe and containing. Participants acknowledged the emotional strain placed on the interpreter when offering their service in what can be very emotionally charged and demanding therapeutic work. Interpreters were acknowledged for their professional skills and the depth of knowledge they held in two or more languages. Interestingly, participants spoke of the importance of the relationship between the interpreter and themselves with some suggesting that this professional, co-working relationship is more important to the therapeutic outcome than that of the therapeutic alliance with the client. There seemed to be a number of factors as to why participants valued the role of the interpreter, in perceiving them as an important member of the triad and fully involved in the therapeutic process. Such factors included the degree of opportunity the participant had to work with the same interpreter; whether the interpreter

was NHS trained and aware of psychological issues, and the degree of trust between the participant and the interpreter.

4.4.1 Example Matrix for main category 2: The therapeutic relationship perceived as a 3-way triadic process.

The example matrix below demonstrates how the sub-categories, focus codes and initial codes were developed from the primary interview data (please refer to appendix XV for a more in-depth version).

SUB-CATEGORY	FOCUS CODE	INITIAL CODE	RAW DATA
Acknowledging the valuable professional status of the interpreter	Learning from the interpreter	Co-working can increase cultural awareness and improve understanding.	<i>I've learnt masses from interpreter about cultures and, you know, they've added things to my understanding.</i>
		Co-working with an interpreter can lead to personal development and cultural sensitivity	<i>There's been an immense amount of growth for me, because I've learnt more about culture and about the way people are socialised and educated in other parts of the world.</i>

SUB-CATEGORY	FOCUS CODE	INITIAL CODE	RAW DATA
	Acknowledging the dual role of the interpreter	The interpreter as a cultural broker.	<i>You can sometimes use the interpreter when the client's not there, obviously, to ask about the culture, and sometimes the interpreter will, tell you things that they've picked up, that I might've missed.</i>
		More than a word machine- the interpreter is a facilitator	<i>It's not just about passing words backwards and forwards, they're [the interpreter is] a facilitator.</i>
	Complex skills involved in translating between languages and cultures	Admiration for the interpreter's professional skill	<i>I hugely admire most of the interpreters we use, because they have fantastic memories, and manage to, you know, allow the client to speak, but also to retain such a lot.</i>
	The triad opens up new possibilities for working with certain groups	Co-working helps improve flexibility making psychological services more accessible	<i>There is a large percentage of population who are referred to us and, you know, we have to kind of find a way of being flexible and providing them with the kind of maybe different kind of way of working. And then we need the interpreter to help us do this.</i>

SUB-CATEGORY	FOCUS CODE	INITIAL CODE	RAW DATA
		<p>Clients benefit from the co-working triadic partnership</p> <p>Seeing the bigger picture, it's about improving access and extending psychological support.</p> <p>Co-working helps to challenge one's personal assumption</p>	<p><i>When it's gone well, the client definitely, you know, has benefited from it as well, and the interpreter's been, yes, you know, just as important to the relationship as me in those times.</i></p> <p><i>If you think about the bigger picture, at the end of the day we're doing it to help these people, to improve access and see if we can give them a chance as well to, to have therapy or counselling, so if that's the ultimate aim, it's a very good thing to have interpreters working with us.</i></p> <p><i>In terms of, you know, the insights into cultures that one wouldn't get otherwise, and again, challenging one's own assumptions about those things, not even pretending to understand stuff that we can't, that's humbling stuff as well.</i></p>
	Addresses issues of equal opportunities and increases service accessibility		
	Working cross culturally with interpreters helps practitioners address prejudice views and misconceptions		

SUB-CATEGORY	FOCUS CODE	INITIAL CODE	RAW DATA
Importance of building a trusting co-worker relationship	Building a co-worker relationship	When the working relationship is considered as being supportive the interpreter is perceived as adding value to the therapeutic work rather than as an impediment	<i>It's [the co-worker relationship] very supportive. So I don't see her [interpreter] as an impediment in our sessions. I see her as somebody who adds value to my sessions and I guess that's a really important point.</i>
	Importance of professional trust	Working together to move the therapy forward	<i>You almost become one. You pool your resources, in a sense, to move forward.</i>
		Importance of working with an interpreter one trust and is comfortable with	<i>There are some people who I am now just completely relax, you know, I kind of almost forget that I'm working with an interpreter now. I kind of have faith that they, you know, are making this process as seamless as possible.</i>
The symbolic triangular sitting Arrangement	The sitting arrangement of	Working with an interpret one is confident and comfortable with influences the therapeutic process	<i>When I worked with certain interpreters that I was confident with, you would feel the difference in the room, and you would feel the shifts happening.</i>
		Acknowledging that the interpreter is part	<i>I'm happy for the interpreter to sit between myself and</i>

SUB-CATEGORY	FOCUS CODE	INITIAL CODE	RAW DATA
	members of the triad as being symbolic of the therapist perception of the interpreter's role within the therapeutic work	<p>of the relational dynamic-this is symbolically represented in the sitting arrangement</p> <p>The arrangement of the chairs represents the equality between the members of the triad.</p>	<p><i>the client, rather than behind or something, because I want them in the space too, to get the best out of that dynamic</i></p> <p><i>I would always have it that it is an equal amount of distance between the three of us. And the chairs are more or less, maybe, or kind of almost facing towards a centre point, so no one person is left out..... But I still think it's important that the chairs are equal, because the interpreter is just a part of that relationship, so that's how I do it.</i></p>

4.4.2 Acknowledging the Professionalism of the Interpreter

For many of the participants the role of the interpreter was considered to be more than that of a translation machine.

This point is emphasised by Joshua:

It's not just about passing words backwards and forwards, they're a facilitator.

Mia highlights the lack of understanding among therapist of what the process of interpretation actually requires:

Often in meetings when we talk about our experiences when working with interpreters people... therapists, especially therapists of psychodynamic kind of background, are quite insistent that the interpreter should not provide any interpretation other than just strict translation, word for word translation. And I often think when they say that, that they don't understand what it's like to translate because, you know; if you translated language word for word literally it would sound really odd.

Sebastian points out that the interpreter can also act as a cultural adviser:

It can be really useful to get some context from the interpreters as well.

Sophia makes a similar point:

You can sometimes use the interpreter when the client's not there, obviously, to ask about the culture, and sometimes the, the interpreter will, tell you things that they've picked up, that I might've missed.

Sara points out how working with an interpreter has improved her understanding of other cultures:

I've learnt masses from interpreters about cultures and, you know, they've added things to my understanding.

Sebastian makes a similar point:

There's been an immense amount of growth for me, because I've learnt more about culture and about the way people are socialised and educated in other parts of the world.

Interestingly, Joshua draws attention to how having another person who is of the same or similar culture as the client can open the therapeutic space:

When you have two people from very different cultures, when you have someone from the same culture in the room as well, I think that tends to open things up a bit, and that, again, improves the dynamics.

The implicit suggestion here is that the interpreter can act as a mediator in the development of the therapeutic alliance.

Many of the participants also acknowledged that often interpreters have to manage immense psychological strain without adequate supervision or having received the psychological training to work in mental health. Emily expresses her concerns regarding this area:

I'm not sure always about the training of interpreters but, you know, they're facing emotional material that sometimes in assessment is very graphic, very detailed, very full-on, and sometimes it is a bit overwhelming and also I wonder sometimes if they're interpreting for someone from their own culture and perhaps from their own home country, how much of that is common; how much of that is a shared experience, and how difficult that is for the interpreter.

Joshua describes how having to listen, process and translate the client's discourse can place the interpreter in a difficult position that is emotionally exhausting:

If I'm affected by a client's distress, the interpreter is going to be as well. So I have to be quite mindful, and to keep, you know, a partial mind on how they're experiencing, because they become a filter, and sometimes, where they become a filter, they're the client and they can, you know, it's probably quite difficult for them to process things.

These quotes illustrate participants' awareness of the importance of the contributions made by interpreters as many of the participants acknowledged the diversity of the role of the interpreter in offering a translation service as well as their contribution to culturally informing clinical practice through their knowledge and understanding of the client's cultural context.

4.4.3 Acknowledging the contributions of the Interpreter on the process of therapy

Many of the participants spoke of how important the contribution of the interpreter can be to the overall outcome of therapy. Tamara explains the importance of the role and the contribution of the interpreter in terms of the progress of therapy:

I can definitely think of a good few cases where we've had such a great outcome with the client work, and what we've done has been so effective, and at the end of it, the client has fed back to us that they felt they were able to make that progress because they felt comfortable, and they could trust both me and the interpreter. So it kind of...those times

have really highlighted to me just how important the interpreter is. So when it's gone well, the client definitely, you know, has benefited from it as well, and the interpreter's been, yes, you know, just as important to the relationship as me in those times.

Sophia speaks about a particular client who has experienced a lot of abuse but is doing really well in therapy and who seems to be benefiting from the triadic set up:

I think it's the triad that's helping her, and, erm, that's been quite therapeutic for her because what we represent there is more of a, we become an extended family in there, like three sisters, this is the type of transference that I can see, and she has, she does have sisters, she does come from an extended family, they don't live here, they live all over Europe, they've spread. But I think we are recreating, we are in a way enacting a positive dynamic, and it seems like we are three sisters, and she finds it very, very accepting, she finds the environment validating, she has been able to open up, both to myself and to the interpreter.

Sara explains how the interpreters input can improve the quality of the service:

The interpreter can actually add to the quality really, and the experience. They can make it more containing for the client, they can certainly add to one's own sort of cultural knowledge, which often is very limited, so it can be very useful, you know, working well. I think it can be a very positive experience.

Unlike the statements that characterised the previous category, in which the role of the interpreter was considered to be that of a mechanical voice channel, in this second main category, the role of the interpreter is extended and more flexible. In the statements that constitute this second main category, the interpreter is considered as a valuable member of the triad adding to the clients' experience of therapy as well as acting as a cultural adviser to the participant.

4.4.4 The Interpreter recognised as an Asset to the therapeutic work

In contrast to the statement he made at the start of his interview, whilst speaking of the benefits of working with interpreters Sebastian comments:

I don't see her [the interpreter] as an impediment in our sessions. I see her as somebody who adds value to my sessions and I guess that's a really important point.

Like many of the participants Emily notes how satisfying this area of her work can be:

It's [the triad] harder work and it's very intense but possibly, you know, the more rewarding for it.

Tamara explains how enjoyable this work can be and that a good interpreter can be beneficial to the clinical work:

I actually quite enjoy working with interpreters, because I think when they're good at what they do, they can be a real asset.

Likewise, Mia values the service that the interpreter provides:

I look at interpreters in a positive way. I'm kind of grateful for them, for being there and to them for providing the service. And I know it's not easy.... I have great respect for them and gratitude for their help.

Sara takes this point further, as she explains:

When it really goes well, and you really have, you know, the interpreter's able to communicate not only the story, but really, you're really getting a sense of the emotions behind it, which you wouldn't have, it's a bit like you go beyond a wall that you wouldn't have got to without the interpreter.

In both these and other similar statements participants showed sensitivity to the need to work with interpreters highlighting the important contribution interpreters make in providing a more inclusive service to clients

4.4.5 The importance of the co-worker relationship

There appeared to be a number of factors as to why the participants' perception of the interpreter shifted from being an impediment to the therapeutic work to being an asset to the clinical work. In particular, this seemed to be linked to the professional relationship

between the participant and the interpreter. For example, the number of times the participant had the opportunity to work with the same interpreter seemed to be an important factor in developing the co-worker relationship. Often when speaking of their experience of working with interpreters in a positive light participants did so in relation to a particular interpreter with whom they have worked with on many occasions.

Sara's experience of working with the same interpreter is insightful in understanding why such an opportunity can help in shifting the relational dynamics between the participant and the interpreter:

I worked with the same interpreter for around a year and a half, so it was quite different sort of work. And I think, in a way, I was quite fortunate, because that's very different from like working with a different interpreter each week. So I really had a chance to look at how it was working, build up a good relationship with the interpreter, and to think about the dynamics over a long period of time, and to discuss with the interpreter as well, who I became quite close to.

Mia also prefers to work with the same interpreter:

I'm used to working with this interpreter and we work again and again together and I kind of by now feel quite relaxed in that partnership... We work as a team.

Likewise, Naomi also links a good working relationship with the opportunity to work frequently with the same interpreter:

I have practised the therapy in a GP surgery and have been fortunate enough to be able to use the same interpreter over that period of time...So there's a very good working relationship that I have with one particular interpreter.

The opportunity to work with the same interpreter seems to help in developing trust which many of the participants highlighted as being crucial to a co-worker relationship. The importance of establishing a trusting professional co-worker relationship is stressed by Sebastian:

Because I have a relationship with her, an established relationship, a professional relationship, when I know that I'm working with a new client with her, there's no trust to be built between me and her – it's just trust between us two and the client, or else if I get a new interpreter I've never worked with before, there's three people in the room then. So that makes it tougher. You know, the interpreter's got to build trust between the client and the practitioner, and the practitioner's got to build trust between the interpreter and the client, and then the client's got to build trust between the interpreter... and so the dynamics are much more difficult.

The trust, which most of the participants spoke of, appears to develop as a result of both the frequency of which the participant and interpreter have worked together and also if the participant perceives the interpreter as holding a professional status or displaying traits that are considered to be professional, such as, being on time, attending to the task of translating whilst refraining from making personal interpretations and being able to maintain a relational distance between the client and themselves. Once established, this trust seems to defuse the element of anxiety that is often associated with being in a position of uncertainty. In other words, it might be that when participants are able to trust the interpreter they are better able to tolerate being in a position of not knowing, thus loosening their need to be in control of the situation and relational interactions.

The opportunity to work with, and consequently build trust with a certain interpreter seems to have a positive impact on other aspects of the therapeutic process.

Naomi comments on how the relationship between the interpreter and herself can have a positive effect on the clients' experience:

There is quite a good relationship between me and her, the interpreter, that kind of gets in a way projected onto the client and she, the client, feels safe so the interpreter is, helping the client feel safe and understood.

Another important factor that appears to have an impact on participants' perception of the interpreter as a co-worker is the professional background of the interpreter. If an interpreter had received NHS approved training and was aware of psychological issues then they were almost considered higher in the professional hierarchy. There is of course the possibility that the higher the perceived professional status of the interpreter the more likely it is for the participant to consider themselves as being equal and thus more willing to accept the interpreter as an important member of the triad. If one accepts that professionalism is a socially constructed concept then one can better understand the social constructionist view of how certain constructions of what is and is not professional can influence people's interactions and their overall relationships.

Sebastian puts forward a good argument for the need to work with interpreters who have specific NHS mental health training:

I guess, as a sort of analogy, if I was a really skilled surgeon, would we just bring somebody in as a theatre technician who wasn't trained, but knew how to handle scalpels and what have you, and make beds up and stuff, you know. It wouldn't happen, would it? They'd make sure that the people who work in that theatre were all trained to NHS standards before they're allowed anywhere near their patients, but, like, it might not be a good analogy, but I think that with us, we allow people into our "theatre" that are not trained to NHS standards and I don't think that... I think there's a real ethical question there.

Sara also notes the importance of both training and being psychologically informed:

I've worked with a number of extremely good interpreters who are not only well trained, but who have an understanding of mental health issues, which makes a huge difference.

Alex's description of professionalism is characterised in terms other than training alone. This suggests that professionalism consists of particular personal traits and ways of behaving:

I have been quite fortunate, I think, in that the interpreters I've worked with have been very, I've found them very good at their job, especially in terms of sort of personal skills, they've been quite relaxed, they've been quite open. They've been prompt, you know. I've been lucky as well, I think, in terms of their commitment. They've turned up, they've been on time. They've let me know if they can't make it, in advance.

These statements suggest the importance of the professional relationship between the participant and the interpreter. The opportunity to work with the same interpreter over a period of time seems to be an important factor in developing a trusting co-worker relationship, as does the participants' perception of the interpreter as displaying traits that are associated with professionalism. Overall it seems that when participants are able to trust the interpreter they are better able to tolerate being in a position of uncertainty. Trust therefore seems to help abate participant anxiety around working with an interpreter within the clinical practice of a triad.

4.4.6 The Triangular Seating Arrangement.

As was the case with the previous category, the seating arrangement that was representative of this category also seemed to be symbolic. In other words, where participants accepted the interpreter as an important member of the clinical work the chairs would be arranged so that the members would be seated in the form of a triangle. This symbolically indicates equality, with each member being of equal distance apart and facing a centre point.

This is illustrated in Tamara's statement:

I would always have it that it is an equal amount of distance between the three of us. And the chairs are more or less, maybe, or kind of almost facing towards a centre point, so no one person is left out.....I still think it's important that the chairs are equal, because the interpreter is part of that relationship, so that's how I do it.

Joshua is also happy with the triangular seating arrangement:

I'm happy for the interpreter to sit between myself and the client, rather than behind or something, because I want them in the space too, to get the best out of that dynamic.

Naomi considers how having the interpreter sit behind the client is an implicit indication that he or she is not part of the therapeutic process:

I've heard horror stories of having interpreters sitting behind the therapist, and then the clients then, and they're just kind of like, almost, the client can't even see them, but just hear them, and that to me kind of really, is a horror, horrific, in the sense that I, believe that they are part of the relationship, to be included.

Mia explains how certain approaches to therapy imply that the presence of the interpreter should not be acknowledged. She notes how unnatural this feels and that it is in essence an attempt to disregard the interpreter and a form of avoidance of the situation for what it is:

Some schools of thought are that neither the client nor the therapist should look at the interpreter during the session. That they should look at each other and the interpreter should provide this voice that interprets what's being said. I don't adhere strictly to that. It feels unnatural and it feels disrespectful to the interpreter...I tried doing it the way that, you know, I was told I should be doing it but it felt somehow as if you're pretending that she's [the interpreter] not there, but she is there.

In consideration of the first main category, these statements seem to be suggesting that participants considered working with an interpreter as being helpful in opening the therapeutic space. With the support of the interpreter the client can be made to feel more contained and safe in the process of therapy, whilst the participants benefit from the interpreter's insight into the client's cultural background. Overall, this category demonstrates that at times participants acknowledged the professionalism of the interpreter and that by doing so they seemed more willing to share the title of expertise. This consequently changed the dynamics of the relationship in which the interpreter was perceived as being more of a co-worker in offering therapy to the client. It seems that

during a relatively short space of time participants moved between considering the process of therapy as consisting of, a 2-way dyadic process and that of a 3-way triadic process. In the first instance the role of the interpreter is compared to that of a function of a voice machine whilst in the latter case the interpreter is considered to be a valuable and equal member of the triad,

4.5 Core category: A Tension in the therapeutic triad with an interpreter.

It seems that the participants struggle between two opposed positions of how to meaningfully work with interpreter within the clinical practice of a triad: either the clinical work is considered to remain as a dyadic relationship or is acknowledged as involving a triadic process. The interview data indicated that participants were pulled between these two clinical styles. Often the participants (and the researcher) seemed unaware of this tension. This category did not arise as a conceptual category until after the interviews were completed, and so this matter was not raised or prompted with the participants during the interviews.

This tension was demonstrated by Naomi who commented “*It’s almost like a tension in the room*”. Sophia also indicated some tension in her statement that “*Sometimes it’s as if there’s far too many people in the room*”. Sebastian’s interview highlighted a potential contradiction. At the start of his interview Sebastian explained that he considered having to work with an interpreter as being an impediment to his practice, but later on he explained how he did not regard the interpreter as being an impediment. The data suggested that there were a number of factors which contributed to the uncertainty in this area of work and possibly why the participants struggled in terms of how to relate to the interpreter.

The difference in professional status assigned to that of the interpreter and the therapist appeared to contribute towards the difficulty in developing a professional relationship. The lack of professional recognition seemed to place interpreters in an unequal relationship with the participants. Indeed many of the participants viewed themselves as being in charge and responsible for the overall clinical work.

Another factor that seemed to add to the tension experienced in the triad was the role ambiguity that is apparent in this area of work. Many of the participants spoke of a need to establish role boundaries and made it clear what their expectation of the interpreter was, so to avoid any confusion of who was the therapist in the room. Emily spoke of the problem of interpreters becoming too involved in the process of clinical work to a point where:

They get carried away and they take over as the therapist really.

Naomi also touched on how some interpreters can engage with clients to a point of taking on the role of the therapist:

Engaging in too much conversation with them outside in the waiting room, talking about things that they should not be talking about with them, almost asking them, how are you, oh I'm sorry, you know, and getting into some kind of, pretend therapist.. Empathy to a point, but not take, try to take on the role of the therapist.

The irony in this statement is that whilst the interpreter's role is not considered to be the same as that of the therapist, they are nonetheless expected to adhere to the client –therapist boundaries.

Furthermore as Mia highlighted, there are occasions where an interpreter has translated for the client in a different context such as a medical appointment:

Some of our interpreters tell me that they've interpreted for the same person in a medical setting, so they know each other from before.

A question which then arises is to what extent the participants think they have the right to control the relationship between the interpreter and the client outside that of the clinical context of the therapy room.

In contrast other participants spoke of how the role of the interpreter merged with theirs in the process of performing therapy.

Joshua describes this well:

In a sense, yeah, we were almost merging, in a sense that it has to be sort of almost like one person. So I guess he [the interpreter] would have to become, sorry, that's really mad, no, sorry. I guess he acts as a kind of interface almost, almost, not like a mask, but something that I can slip on, in a sense, to perform the work. And it's not an inanimate object, it's, you know, it's alive, it's organic.

You almost become one. You pool your resources, in a sense, to move forward. And I guess it must be the same. But I guess as well, maybe it's about the boundaries between the three in the room, that they're not rigid boundaries, they have to have some blur and fluidity as the therapy moves.

The dilemma about how much participants were leading the work or whether they were being left out of the interaction also challenged the position or role of the participant as the therapist. Consequently, at times participants spoke of feeling deskilled and disempowered in this work.

This was clearly illustrated by Sara:

I've sometimes felt unprofessional when it doesn't go well, you know, if you're really not, you're not able to run a normal session if you like, one's left feeling, well, that's, you know, going backwards.

I suppose maybe a little bit more in the earlier days of, you know, sometimes feeling relatively de-skilled, when it's not going well, or there's just difficult silences going on, which you'd much rather manage just one to one. I think I worry about that much less

these days, you just do the best that you can, don't worry about what other people are thinking as much.

In this last statement Sara indicates her concern of how she will be judged in performing the role of the therapist. This suggests that in the course of social interactions people are constantly evaluating their performance of a particular social role and are perhaps modifying their behaviour and interactions as a result of others expectations. Performing to others expectations seemed to be an important reason why participants felt uncomfortable in this area of their work.

Sebastian explains the influence of the perceived expectation of him as the expert by the interpreter:

I think that a lot of the interpreters expect you to be an expert.., it got to about 25 sessions where I started to sort of like relax, be a bit more confident in myself and my own ability and, I guess, take the pressure off me, you know, because I just thought, well, you know, I can only do so much.

Sophia outlines how the client's expectation of both the therapist and the interpreter can affect how the client relates to the other two people in the room:

Sometimes you can see clients, I won't use the word idealisation, not idealising me but respecting me more than the interpreter, and I've also seen at times clients feeling warmer towards the interpreter and relating to them in a more comfortable and loving, if you like, way than relating to me who I present as the expert, the professional, the more distant kind of figure.

Naomi also touches on the clients' expectation of her as an expert and the potential confusion this can create for the psychological nature of therapy:

They [the clients] think that you're gonna be like their GP, where the GP expects to hear physical symptoms, mainly, don't they, really, even though they look out for psychological but, but that you're gonna give them something to fix it.

Sara seems to be suggesting that whilst the client considers her as a professional they may not perceive the interpreter in the same light:

They [the clients] trust we're professional, we're working in a professional world, but the interpreter is out there in the community with them, somewhere in the same community.

These quotes highlight how important socially constructed roles are in any social interaction. Such expectations not only seem to be influential in how the person perceives and judges their own sense of professionalism, but also how members of the triad relate to one another during the course of therapy. Overall the positioning of the participant as a professional authority figure within the context of a therapy room seems to be partly responsible for the tension in the triad. It is possible that participants find it difficult to share their position as the professional expert with the interpreter. This then causes a problem of how to conceptualise the role of the interpreter and their contribution or influence in the process of therapy.

In addition to individual expectations, the broader societal context also appeared to create pressure for participants, in terms of perceived professional expectations. The organisational pressure of the NHS seemed to make participants resentful of having to work with interpreter within the clinical practice of a triad. It can be that some of the resentment and frustration participants felt due to organisational demands was directed towards the interpreter who represents an aspect of this work that participants believe they have little control over.

Alex illustrates this point well in her comment:

It is such a huge area where you kind of are expected to meet the same competencies, but you feel like you've got a whole other element that you're trying to manage as well. And it doesn't seem to be supported. It doesn't seem to be talked about or discussed, or kind of given a lot of attention, within training, but also within practice.

Perhaps for these reasons most of the participants indicated that if they had the choice they would rather not work with an interpreter. Even though they acknowledged that it is the only means by which some clients can have access to therapy.

Joshua explains:

It can be quite a selfish thing, maybe, that I think that's going to be too much hard work. I wouldn't skip them in the waiting list, and I don't go and think, oh no, you know. But I think I don't positively look forward to it, if that makes sense.... Given the choice, I would choose not to use an interpreter. I find it quite hard work.

Mia explains how this area of clinical work can feel like a punishment:

I remember when I first started working in a service we were arguing who's having more patients with interpreters and who's having fewer and whether there should be a quota. It was almost like a punishment.

Although Sara acknowledges that working with interpreters allows certain client groups the opportunity to benefit from therapy she is nonetheless happy to avoid working in the triadic style of therapy.

If they [interpreters] allow some clients who are, you know, operating at almost Cinderella level in the country, some of these clients, you know, where they're always being pushed down because they don't speak English, they don't have things properly explained, and then they miss out on benefits, you know. One thing leads to another, and then they get angry, and then they get named as a bit of a troublemaker. One thing leads to another horribly. And, we're all human and make assumptions about people, and I think sometimes when you get behind all of that, with the help of the interpreter, I think that's very humbling as well and I try hard to hang on to some of that....

I think it is still something, working with interpreters, that overall, I am happy to avoid. I don't think I do avoid it, but I'm happy to avoid it, because it brings a certain heart sink about it, because it's hard, and it's tiring.

This core category aims to demonstrate that there exists a conceptual link between the first two categories. The interview data suggests that when speaking of their experience of working with an interpreter participants struggled to meaningfully conceptualise the relationship between the interpreter and themselves. On the one hand participants acknowledged the importance of the interpreter and their professional skills in the process and progress of therapy. However, considering the clinical work as consisting of a triadic

relationship raised a number of problems. Firstly having acknowledged the professionalism of the interpreter requires the participants to share the position of expertise. The unfamiliarity of the triadic work and the loss of language is a source of anxiety. Even if only temporarily, this loss causes a sense of insecurity which participants seem to find difficult to manage. Consequently in an attempt to abate anxiety participants hold on to their position as the all knowing expert and thus consider the work as a dyadic relationship and the function of the interpreter as a voice machine.

Overall there are both advantages and drawbacks to taking either the triadic or dyadic therapeutic frame for working with a bilingual interpreter. Speaking of this style of clinical work as being a triadic relational process implies that the practitioner is reflective, open and confident in his or her professional practice. He or she is able to cope with being in a position of uncertainty which arises from not knowing the actual conversation between the interpreter and the client and having to depend and trust that the interpreter is conveying information truthfully. On the other hand the one-to-one style of the dyadic frame offers a sense of security, certainty and seems to reduce anxiety as it draws therapist to believing they hold true knowledge and are the all knowing expert within the clinical practice. In turn it seems that taking either one of these positions has certain benefits for the practitioner. Consequently tension results as practitioners struggle to decide between these two therapeutic styles when working with interpreters in offering therapy to clients with limited spoken English.

4.6 Post-Analytic Reflections.

Although there may have been additional triggers, it was noticed that participants changed between speaking of their work with an interpreter as involving either a dyadic or triadic process in conjunction to two things. Firstly, if participants were intentionally directed to reflect on either the advantages or drawbacks of working in the triadic set up of therapy. Secondly, a change seemed to happen on those occasions where either the researcher or the participant unknowingly colluded with the other person's views until either one would notice this and change the focus of the conversation to reflect either the more triadic or dyadic nature of this style of clinical work.

To return back to the inherent tension in this study that was raised in chapter 3, concerning the question of how does the researcher make sense of the dual nature of treating the data as both constructions in the place of the interview and as telling us something about the constructions involved in the therapy room reality of participants. Some could criticise the analyst for slipping unaccountably between a realist reading of the data (the constructions are reporting or referring to a reality outside of the interview talk) and a constructionist reading (the constructions are to do with the interaction within the interview). Whilst this tension cannot be completely resolved, hence an element of tension remains between these two readings of the data, one path way through that leads towards a more accountable analytic process is to consider the contradictions and tensions within the interview as indicating or guiding an analysis of the constructions outside the interview (Billig, 1987; Billig, Condor, Edwards, Gane, Middleton, & Radley, 1988). In other words, drawing on the construction in the contradiction within the moment of the interview interaction and examining the action orientation of the talk there that deals with what is happening in the interview but the dichotomy that is used to do that may take us outside of the interview

situation and may point to a reality that is wider. It may indicate recourse for making sense of the world that was not constructed from scratch in the interaction of the interview but relates to a wider reality, such as the therapeutic encounter itself. As an example of this, it can be seen that in his interview Sebastian drew on two contradictory perception of the interpreter as being both an asset and an impediment to his clinical practice, these contradictions within Sebastian's interview could point to constructions that are taking place within the interview processes but the discursive resources that Sebastian draws on in the interview process may not be limited to the interview itself but refer to reality, albeit a discursive reality, that is important within the therapeutic situation as well.

On reflection because of an interest in both what is happening in the interview as well as the discourses that are operating outside the interview process, the researcher became aware of the potential wider professional implications surrounding this area of clinical practice. In particular, the challenging position practitioners might find themselves in needing to play the social role of an expert whilst still holding onto the value of remaining in the position of uncertainty. Sophia touched on the potential risk of ignoring the wider issues that implicitly influence the triadic relationship with the interpreter. She seems to be suggesting that rather than the relationship itself there are more concerning issues that are often not acknowledged:

I think the danger is in ignorance and avoidance, not in the triadic relationship in itself. I think the danger is when we ignore the issues that may arise in this triadic relationship rather than the relationship itself... I mean, the, the danger is when you don't acknowledge that there might be struggles within this triadic relationship, if you just go into the room and you work as if nothing's happened... I think that's what the main danger is, more so, than the presence of a third person or the transference disturbance. I think the danger is, lies with the denial, like I said, the ignorance.

This chapter presented the findings of this research. The following chapter will consider these findings in relation to the existing literature and research in this area.

CHAPTER 5: DISCUSSION

This chapter outlines the main themes that were constructed through the analysis of the data. These are considered in light of the existing theoretical ideas, research, and in terms of its wider significance to the clinical practice of counselling psychology. Following this, issues pertaining to reflexivity and the limitations of this research are explored with suggestions for improvements being made. Finally the chapter concludes with suggestions for further research in this area.

5.1 A Tension in the Therapeutic Triad.

Participants in this study, spoke of their experience of working in the clinical context of a triad in ways that, at times, seemed to suggest that they continued to perceive the therapeutic relationship as a two-way dyadic process (main category1); whilst at other times, they seemed to accept the therapeutic relationship as a three-way triadic process (main category 2). As the nature of the clinical context of therapy changes from a dyadic to a triadic form, the participants, in this study, seemed to struggle to meaningfully integrate the presence of the interpreter. In addition to the somewhat unfamiliar context of the therapeutic triad the loss of direct communication with the client also seemed to trigger practitioners' need to (re)-establishing their position. Consequently, a tension was observed as practitioners oscillated between speaking of their experience as involving a dyadic or triadic therapeutic process. This tension also exists in the literature between authors supporting a broader role for interpreters within a clinical context (Roberts, 1997; Wadensjo, 1997; Tribe, 1999; Raval & Smith, 2003; Tribe & Keefe, 2009; Tribe &

Tuanariu, 2009) versus those advocating that interpreters should remain strictly as ‘neutral translators’ (Marcos, 1979).

This tension was illustrated by one of the participants who referred to the interpreter as having a ‘passive yet active’ role. Another participant considered working with an interpreter as an impediment to the therapeutic work, whilst at a later stage of the interview he claimed that this was not the case. Still others spoke of the benefits of interpreters in terms of providing a cultural context and enhancing therapeutic containment for the client. At the same time, participants also highlighted the potential drawbacks and complications involved in the process of translating including, loss of content, misinterpretation, and the interpreter intentionally or otherwise diverting the course of therapy. Although unbeknown to the researcher and possibly to the participant at the time of the interview, participants seemed to be caught in a power-struggle with the interpreter. This struggle seemed to be characterised by two separate styles of clinical practice, on the one hand participants seemed to want to hold onto the all knowing professional expert role, and continue to perceive the clinical work as a dyadic process. This position is however at odds with the more reflective stance which requires adopting a more inclusive triadic model to clinical practice. Overall, it seems that a number of possible factors potentially contribute to this struggle and the resulting tension. Of particular importance these include: the existing inequalities inherent in the practice of therapy; the nature and demands of the NHS work; the broader societal context and the gaps in current professional training.

Most of the participants touched on the depth of knowledge and skills necessary to be able to translate between two languages, and acknowledged the need for interpreters to be recognised on a professional platform. However, participants’ use of language implied that within the therapeutic context of the triad they considered themselves as holding the

position of professional expert. Thus the findings of the present study support Spong's (2007) claim that amongst practitioners there exists a temptation to practice from a position of power and knowledge.

Several authors have drawn attention to the power differential arising from interpreter's low professional status and have identified the need for practitioners to be aware of the impact of such power differentials in the development of the co-worker alliance (Smail, 1990; Holland, 1992; Granger, 1996; Aitken, 1998; Tribe, 1999; Raval, 2000). In addition to the potential disadvantages faced by many interpreters in the work environment, participants also identified the possible social inequalities experienced by interpreters as a result of their own ethnic background. Given that many interpreters might be from the same ethnic minority group as the client, some participants wondered about how much of the social disadvantages and disempowerments experienced by the client were also shared by the interpreter. Although, participants seemed to be aware of some of the potential power differentials that exist between themselves and interpreters they continued to slip back into affirming their own authority as the professional expert within the triad. Overall, this need to take on the role of professionalism, expertise, and subsequently the position of power seemed to serve participants by providing a way of abating anxiety in what otherwise could be experienced as a very uncertain social situation.

Furthermore, literature suggests that most practitioners value theoretical knowledge highly (Hoffman, 1992; Mouque, 2005; Laughton-Brown, 2010). In support of this, Lomas (1999) argues that a practitioner's professional pride is intertwined with theoretical knowledge. More specifically, the more a practitioner believes in theory the more he or she feels professional. In view of this argument it is possible that amongst practitioners, psychological theories are considered as constituting truths about human nature and

practitioners pride themselves in holding psychological knowledge. In addition, the practice of counselling psychology is grounded in theory that focuses predominantly on the uniqueness of the dyadic relationship between the practitioner and the client. Thus, within the clinical set up of the triad, the application of theory that values the dyadic nature of therapy is perhaps further complicated by participants holding tightly onto traditional theories and not wanting to recognise that an alternative perspective on clinical practice is needed.

All the participants in this study were employed by the NHS Improving Access to Psychological Therapies (IAPT) services. The introduction of the IAPT services has resulted in large-scale restructuring of the provision of psychological care by the NHS with many existing services and practitioners having to integrate into the process. This was the case for four of the participants in this study who commented on having to work within the remits of the IAPT service after their previous NHS service merged with the local IAPT service. From a critical viewpoint, Risq (2011) claims that as a result of the continual structural reshuffling within the NHS, practitioners experience uncertainties regarding the future of their profession. Similarly, Clarkson, (1995) posits that as a consequence of the current financial and political climate of the NHS, therapists have had to take on a more expert or professional role in order to sell their services and make a living. In support of this Strawbridge and Woolfe (2003), claim that there is increasing demand on psychological professionals to justify their interventions on grounds of evidence based practice and they are required to provide technical expertise in their field. These points might explain why practitioners struggle with the uncertainty that arises from the triadic style, as well as why they perceive the interpreter as judging their interventions, and subsequently feel the need to defend their own professional expertise.

Furthermore, some participants noted the dilemma they faced between having to meet service demands and adequately accommodating the triadic system of therapy. An important question is whether participants would experience the slow pace of the triadic system as being 'frustrating' if they weren't required to reach certain outcome measures which are aimed ultimately to reduce NHS waiting lists. In her article, Risq (2011) adds that the new emphasis of the IAPT services is on using standardised assessments and treatment protocols all of which aim to move clients 'towards recovery' as determined by 'evidence' base measurable outcomes. Needless to say that these principles are not necessarily in unison with the humanistic values from which counselling psychology arose as a profession (Corrie & Callahan, 2000). Therefore it is likely that the anxiety and frustration participants experienced were not only a result of their direct work with interpreters, but also due to having to change their practice to fit the protocols of the NHS. What is more, the current trends in the NHS can be seen as representing the demands of the wider society, where both knowledge and truth is valued highly and the notion of professionalism and expertise is closely associated with having specific knowledge and skill in a particular area (Corrie & Callahan, 2000; Strawbridge & Woolfe, 2003). As such it might be considered unwise and even seen as jeopardising one's career to share the high status assigned to the social role of being a professional expert. In addition, many clients consult the help of a professional therapist with the expectation that he or she will be able to find explanations for their symptoms and might be cautious about seeing a practitioner who does not consider themselves as being an expert. Indeed some participants in this study indicated that partly due to being unfamiliar with the aims of psychological therapies, clients expect to be 'fixed' and confuse the practice of therapy to that of their general practitioner. Moreover, some of the participants suggested that this lack of awareness and confusion regarding the aims and objectives of psychological support was also common

amongst interpreters. Participants spoke of interpreters who expected them to work in a similar manner to that of other medical staff. Consequently, the expectations of both the client and the interpreter might make it more difficult for practitioners to give up and share their powerful social title as the professional expert.

Another factor that seems to contribute to this tension is the existing gaps within professional training. Only one participant highlighted the need to recruit more therapists from those ethnic communities that the IAPT services aim to work with. The profession of psychological practitioners still remains largely made up of individuals from white, middle class backgrounds. Boyle, Baker, Bennett, and Charman (1993) identify the need for professional training courses to recruit more trainees from different ethnic communities. Furthermore it has been argued that clinical training courses need to devote more time, attention and resources to cross-cultural issues (BPS Race and Culture Special Interest Group, 1995). This fits with participants' statements that prior to working with clients from a different culture to their own and with an interpreter they received no formal training in this area of clinical work. Sue and Sue (1990) suggest that clinical training programmes need to expand to raise trainees' awareness of cultural issues relating to clinical practice. They also argue that training courses need to provide trainees with a knowledge base to be able to develop appropriate clinical skills to work cross-culturally and with interpreters. In addition, participants noted that within the NHS they were expected to work with interpreters but that there were no opportunities to receive either in-house or external training in this area. It seems that the failure of clinical courses to better equip trainees to work with interpreters and clients from different ethnic communities continues into the clinical work context of the NHS.

Perhaps as a result of these gaps in both initial and post-qualification training, the need to meet NHS performance standards whilst not coming from an informed position of how best to work within the triad left participants feeling anxious. This might explain why participants felt ‘de-skilled’ and at times experienced the interpreter as passing judgment on their practice. In an attempt to abate their anxiety, take back control and to retreat to a “*secure base from which to work*” (Mackay, West, Moorey, Guthrie, & Margison, 2001, p.33) participants return to the theoretical ideas of clinical practice that are familiar to them. Furthermore, because the models of therapy that are covered in clinical courses are mostly written and developed from a western perspective that values the dyadic relationship their application within the triadic set up of clinical practice becomes problematic. This in turn results in a build up of tension in this area of clinical practice.

5.2 The Therapeutic Relationship Perceived as a 2-way Dyadic Process.

All the participants highlighted the difficulties that exist in working with interpreters when offering therapy to clients with limited spoken English. Participants spoke of the challenges of the triadic system, in terms of both the intrinsic and extrinsic aspects of this work (Grasska & McFarland, 1982). Intrinsic difficulties include those difficulties that are inherent to translation and interpretation; it is not always possible to translate and convey all aspects of experience and human suffering from one language to another in a way that allows someone else to gain full understanding of these. Even in situations where a shared language exists there is no certainty that people will hold a shared understanding of what has been communicated. Extrinsic problems include for example the lack of training for interpreters and therapists when working in this way; the slow pace of the sessions due to having to allocate time for the information to be translated; issues over maintaining client confidentiality when working with interpreters; the limited availability of interpreters and

linked to this the potential difficulty to maintain therapeutic consistency as the interpreter might need to change at short notice. The issue of training or the lack of training in this area was particularly prominent. None of the participants in this study had received formal training prior to working with an interpreter in offering therapy to clients with limited spoken English. Perhaps more alarming was where participants noted that issues concerning the relevance of cross-cultural therapy only constituted a minor part of their professional training. As a result most of the participants said that they had no choice but to learn on the job. The British Psychological Society's Clinical Psychology: Race and Culture Special Interest Group (SIG) carried out two separate surveys, one to evaluate whether issues of race and culture were covered on professional training courses and the other on whether trainees felt adequately prepared to work with individuals from different cultures. The findings of these two surveys revealed that training in these areas could be hugely improved. The findings highlighted the need for additional and comprehensive training and led to the publication of a training manual in 2000 by the race and culture SIG offering guidelines for working cross-culturally and with interpreters (Patel, Bennett, Dennis, Dosanjh, Miller, Mahtani, & Nadirshaw, 2000).

Another extrinsic factor included the nature of the NHS service in which psychological therapy was offered by practitioners. In particular, none of the interpreters that worked with practitioners were actually employed by the IAPT services. The lack of integration of interpreters across the IAPT services, and the low professional status assigned to interpreters within the NHS as an organisation possibly further contributed to the problem of establishing a co-worker relationship. In light of this some authors have drawn attention to the disadvantages faced by many interpreters arising from their low professional status

within the work structures that do not support them (Corsellis, 1997; Crawford, 1994; Tribe, 1999).

Granger (1996) carried out a study into interpreters' experiences of working with other service professionals, including social workers, lawyers, and health care practitioners. The findings suggest that interpreters are often excluded from the professional teams they work with. The interpreters, in the study, expressed their frustration at not having professional status and believed that their skills and expertise as both the translator and as a cultural broker was not recognised in terms of status and pay. Furthermore, unlike those professionals whom they worked alongside, the interpreters received little support or supervision to manage the stressful aspects of their work. On the basis of the findings Granger, (1996) claims that unless interpreters are given the professional credit they deserve the quality of the services offered to individuals from different cultural and linguistic backgrounds is not likely to be equal to those offered to English-speaking clients.

Furthermore, most of the participants stressed the importance of differentiating between the role of the interpreter and themselves. Although participants did not explicitly say so, the way in which they used language implied that, they considered themselves to be the 'true' professional expert in the group, in full charge of the social situation and thus in control of the interaction between the group members. It can be argued that being in charge allows the practitioner to take a more powerful position in the group and hence execute power over the other two members of the triad. The apparent inequality between the two professionals within the triad raises the issue of power disparity in therapy. Patel, (2003) explores some of the issues of power inherent in the therapeutic work with clients from a refugee background with the help of an interpreter and notes that a central question in this work is whose voice matters. She argues that in addition to whose interpretation and

conceptualisations of differences is privileged, whose voice is silenced is also a matter that depends on position and power. Ironically, given that the interpreter is ascribed to the role of facilitating communication then it can be argued that he or she holds a complementary position to that of the practitioner within the therapeutic process. Patel (2003) explains that since both the client and the therapist are dependent on the interpreter to convey themselves, it is more accurate to describe the interpreter as holding the most powerful position. In this respect, each member of the therapeutic triad is symbolically positioned differently. Patel (2003) describes the triad system as the therapist being the driver, the interpreter the vehicle and the client as the passenger. Although it might be expected that the client would be at the apex of the system, traditionally it is recognised that this privileged position is taken up by the therapist who has control over the choice of psychological intervention and possibly the direction of change. However, the position of the interpreter, whose role is to facilitate communication within the therapeutic triad, can in the course of therapy change. The interpreter's preference to select a certain interpretation over others of what the client or the practitioner wants to convey is indicative of the powerful position the interpreter holds in construing meaning within the therapeutic context. Patel (2003) explains that this dependency on the interpreter strips both the therapist and the client of the power to personally express oneself and can create feelings of being silenced oppressed and disempowered by those in a more privileged position. In the case of the practitioner this may be from the structural constraints and professional demands placed on them by the NHS as an organisation.

It is therefore possible that whilst the client does not pose a potential threat to the power equilibrium of therapy, the interpreter can tip the balance and take over the more powerful position that is traditionally held by the practitioner. This argument may go some way to

explaining why participants expressed the need for interpreters to remain within their role boundaries so to prevent the interpreter from stepping into a 'pretend therapist' role.

Indeed, Raval's (1996) study into therapists' experience of working with families with the help of an interpreter found that therapists often experienced the interpreter as taking over the session. Whilst participants defined the difference between the interpreter and themselves in ways that kept them in a more powerful 'expert role', in a paradoxical manner they also expressed feeling disempowered in the triad. Participants in this study described at times feeling excluded from the dialogue between the client and the interpreter which support the findings reported by Raval (1996) and Raval & Smith (2003). It is possible that this sense of exclusion made participants feel anxious about losing control over the clinical work. It could be argued that, the experience of feeling disempowered possibly increased the participants' need to regain control of the work, and thus potentially increased the tension and conflict experienced in the therapeutic triad.

In addition to experiencing detachment as a result of feeling excluded from the dialogue, previously research also suggests that the process of repeated interpretation can make it difficult for mental health professionals to maintain their focus and curiosity about the client (Cecchin, 1987; Raval, 1996; Roy, 1992). Only one of the participants in this study commented on the difficulty of maintaining focus due to repeated interpretation. However, many of the participants spoke of having to allow time for the process of translation and consequently having to adjust to the 'frustratingly' slow pace of working in the triad.

A further challenge to working with an interpreter in clinical practice is managing the loss of direct communication. In the clinical practice of therapy language serves a number of functions. Firstly, psychological therapies rely predominantly on verbal communication. Language therefore provides one of the fundamental ways through which to promote the

development of the therapeutic alliance with the client. Secondly, from a symbolic interactionist perspective, language plays an important part in our understanding of how to do social roles, within a given social context and in the presence of others (Mead, 1934; Blumer, 1969). It is therefore possible that the loss of a shared language, contributes to the apparent role ambiguity, adding to the overall uncertainties experienced by participants when working in the triadic system of therapy.

Although participants expressed a desire for the interpreter to offer an entirely neutral ‘channel’ through which therapy could proceed, they also acknowledged that, this was not entirely possible. According to Mudarikiri (2003) “*there is no active observer to an interaction who does not influence what he or she observes*” (p.190). He therefore argues that it is unhelpful to assume that the interpreter will be able to carry out their work without bringing to the interaction their unique cultural or familial context or views and opinions. Indeed, most of the participants gave examples of cases where they believed that the interpreter’s own political, cultural, religious and other value judgements coloured his or her particular choice of interpretation or influenced the process of therapy. For example, Sebastian spoke of an incident whereby he thought that the client was unable to express his anger because the interpreter was not keen on shows of aggression. Likewise, Mia reflected on a particular experience in which the interpreters’ conceptualisation of gender roles had directly entered the therapeutic work.

The social constructionist perspective argues that relationships between people exist within the meanings that can be created through language. Therefore it is through language that people experience their world, and so it is within the parameters of language that people’s relationships, feelings and emotions come to life (Burr, 1995). Authors have explored the therapeutic dyad and the unique relationship between the various communication partners.

Tribe (1998) explains that psychologists who use interpreters in their clinical practice have to learn to negotiate the two relationships and it is therefore not surprising that one of the partners may feel excluded. Hillier, Huq, Loshak, Markes and Rahman (1994) report that when therapists have to use an interpreter to work with a client they are more likely to have a lower opinion of their effectiveness, thus doubting their own abilities. This is further exacerbated by the fact that all verbal communication is directed through the interpreter and so there may be a shift in the authority from the therapist to the interpreter, reinforcing the notion that the therapist is not doing a good job. The experience of the participants in this study resonates with these findings. Although perhaps not as prominent as during their initial experience of working in the triad, several of the participants expressed concerns about feeling judged by the interpreter and, or at times feeling de-skilled in this area of their work.

On a separate note almost all the participants acknowledged the potential emotional strain interpreters faced when working in the field of mental health. Participants were particularly unsure of whether interpreters received supervision or had relevant training in managing emotionally charged material and how this might affect their work in the course of therapy. In support of this a study by Tribe (1998), which focused on a support and supervision group for interpreters, found that interpreters felt overwhelmed, or were afraid of being overwhelmed, by the client's material being addressed in therapy, and were concerned about the effect this would have on the other two people in the room. Furthermore, authors like Sande, (1998) stress that psychologists have a duty to offer emotional support to interpreters employed in mental health and that the profession needs to be sensitive to possible vicarious traumatisation.

In all the interviews there seemed to be an implicit resistance on the part of participants to fully acknowledge the triadic nature of this work, with some participants clearly indicating that if they had the choice, they would rather not work with interpreters. In part this resistance could be linked to professional training whereby the focus is on learning theories and models, in which “*the dominant discourse and language was developed in the west and encapsulates many of the cultural perceptions developed here*” (Tribe, 2007, p.160). Consequently, the dominant theories in psychology are not only culturally-bound, but also focus primarily on the importance of the dyadic therapeutic relationship (Clarkson, 1995). It could be argued that the traditional dyadic nature of therapy makes it difficult to incorporate the presence and influence of the third member. In addition to this is the issue that within the current NHS culture professionals are expected to meet certain performance outcomes and this is perhaps particularly so of the IAPT services (Risq, 2011). In relation to this most of the participants spoke of the difficulty of having to juggle the need to meet service demands and performance expectations with the need to slow down and accommodate for the requirements of the triadic system. It is therefore possible that due to the various levels of complication involved in the clinical practice of the triadic system, participants appear reluctant to let go of the dyadic relationship. In comparison to the triad which is full of uncertainties that naturally stir up tension and anxiety, the dyad is familiar, certain and subsequently safe. In line with this argument it then follows that participants attempted to abate anxiety by continuing to perceive the therapeutic triadic system as if it was a dyadic relationship.

5.3 The Therapeutic Relationship Perceived as a 3-way Triadic Process.

Despite some of the apparent difficulties of working with interpreters, the importance of their role in acting as a bridge between two cultures was acknowledged by all the

participants. Nearly all the participant's, in this study, described how working with interpreters, offered them the opportunity to gain new insight into the clients' cultural background; helping them to better understand and contextualise the clients' difficulties. Participants also suggested that the involvement of interpreter helps to give meaning to culturally specific behaviours and helps to develop culturally sensitive dialogues. These findings support previous research by Raval and Smith (2003) which suggest that working with interpreters helps to inform practitioner's cultural awareness.

Furthermore, Raval and Smith (2003) explains that to achieve effective co-working, it is important for both the therapist and the interpreter to become familiar with each other's context. On the contrary, tension and difficulties are likely to arise when the therapist and the interpreter have not reached a mutual understanding of where the other is coming from. For example, if an interpreter has little experience of mental health work and is unsure of the rationale underlying a particular line of questioning adopted by the therapist, then it becomes difficult for the interpreter to represent the therapist, especially when translating questions that cannot be translated verbatim, but which need an explanation before the client can answer them in a meaningful way that generates information for the therapist to use. Raval and Smith (2003) claims that difficulties such as these can be avoided by allocating discussion time before starting a piece of work which requires the aid of an interpreter. Although some of the participants, in this study, also indicated a preference for allocating time to discuss and prepare for the session, this was however not part of routine procedure and only seemed to apply for those situations where the participant was working with a new interpreter for the first time. The findings of this study suggests that the difficulty to leave time either before or after sessions seem to be linked to the general time constraints associated to a hectic working schedule. However, interestingly when

participants reflected on their positive experiences they often referred to those interpreters whom they had the opportunity to work regularly with and consequently had formed a good working relationship. This suggests that the more opportunities the two professionals have to work with each other, the more likely they are to become familiar with one another's context, and over time this enhances mutual understanding and helps to foster a good working relationship.

Although participants shared their concerns about the complications involved for the client to trust two people, overall participants appreciated that without the help of the interpreter, this client group would not have access to services offering psychological support.

Furthermore, most of the participants in this study recognised that in certain cases the presence of the interpreter can promote therapeutic containment, thus helping the client to feel safe in the presence of two professionals. Therefore, the findings of this study do not support the findings of a study by Kline, Acosta, Austin, and Johnson (1980), which showed that practitioners thought that clients who were interviewed with the help of an interpreter would feel less helped, less understood and would be unlikely to return to the service.

On another positive note, the findings of this study suggest that, at times, rather than view the personal qualities of the interpreter as being a barrier to the work, participants seemed to accept that these qualities will inevitably form part of the clinical work and appeared willing to embrace the triadic system. To this effect, when working with an interpreter in offering therapy to clients with limited spoken English, practitioners are encouraged to consider alternative ways of practicing therapy and to remain open to different possible explanations and beliefs about the clients' problem. For example the multi-dimensional position offered by Falicov (1995) draws attention to the possible tension that can arise

when practitioners hold too rigidly to a 'universalist' position of human distress. The mismatch between the practitioner's theories and the information or causal explanation offered by the client can lead to frustration with the practitioner possibly becoming dismissive and disengaged with the client. In such situations, the interpreter is ideally placed to provide a contextual framework that facilitates a level of consensus between the practitioner and the client.

Mudarikiri (2003) suggests that to incorporate and utilize the interpreter's skills effectively requires a model of working that encourages inclusiveness. Such a model of working encourages the interpreter, the client and the practitioners to feel empowered to take a collaborative, active and more involved role in the therapeutic encounter. This inclusive model, which views the interpreter as a bilingual health or social worker in their own right, may go some way to address the power inequalities that are inherent in this area. From this perspective the triadic system can be evaluated as a three-way process of communication, making it possible to explore the various different understandings of the same observation. It is therefore possible for alternative viewpoints to emerge and give way for new understandings to develop in a mutually respectful manner, hence creating a more reflective, flexible and open therapeutic space. Overall, when each of the participants involved in the triad feels able to make an informed contribution to the therapeutic conversation, it is possible to entertain different exploratory models of the client's difficulties leading towards culturally appropriate diagnosis, formulation and intervention for the client's presenting difficulties.

At times during the interview, participants seemed to take up a more inclusive approach to their practice, whereby the interpreter was considered as having an active and important part in the clinical work. During such times participants seemed more willing to negotiate

their position as the only professional expert in the room and thus the person in authority. Furthermore, participants appreciated the professional input of the interpreter and valued this professional relationship. Participants recognised the importance of this co-worker relationship in supporting clients who required the triadic system to access the help they needed. Patel (2003) emphasises the importance of transparency and a willingness to plead ignorance on the part of the practitioner, she argues that this will help to empower both the client and the interpreter and create opportunities to reflect on the process by which therapy is made meaningful in relation to each client. This requires that culture and culturally-shaped meanings are not just explored as if culture is that which is possessed only by the client and the interpreter, but by the practitioner as well. It is therefore necessary that the practitioner invites and joins the client and the interpreter to discuss, scrutinise and challenge the culturally-shaped assumptions that are implicit in the psychological models and methods employed by the practitioner.

Although during the course of the interview participants spoke of their experience from a more reflective and inclusive stance they would often slip back to a more dogmatic position defending their role as the expert. As stated earlier, participants seemed to oscillate between these two positions as the nature of the interaction with the researcher changed from highlighting the advantages and drawbacks of the triadic style of therapy.

5.4 The Importance of the Findings.

This research has explored practitioners' experience of working with clients who require the help of an interpreter. In particular, it has focused on how practitioners understand the role of the interpreter and consequently how they relate to this third person within the clinical context of therapy. As the wave of immigration and asylum application increases, Britain is becoming a diverse nation, and with the changes in the NHS aiming to better

manage and meet the demands of this changing population, the field of mental health is in a process of transition. Within this climate psychologist and therapist are more likely to find themselves in a position of needing to widen their clinical practice. Historically the subject of cross-cultural psychology was discussed more as a matter of interest with only a small group of practitioners considering it to be an important and relevant part of their practice. However, given the needs of today's society and the changes to NHS mental health provisions practitioners are required to adjust their practices to potentially include working with clients from a different culture to themselves and possibly with the help of an interpreter. Consequently, it will soon be necessary for the field of counselling psychology to evaluate its current models of clinical practice and make changes in order to offer a more inclusive and relevant service to the general public. The alternative is that counselling psychology as a discipline might be criticised for being an elitist profession that serves only the more privileged groups in society. Psychological models of therapy might be considered out dated in their clinical application and out of touch with the needs of the existing wider communities.

The establishment of the IAPT services has lead to serious changes in how psychological care is funded. These changes have had wider implication to the provisions of mental health care by the biggest employer of psychologist in the UK (Bor & du Plessis, 1997). As the name suggests, the NHS IAPT services were introduced in an attempt to improve accessibility to psychological therapies. Although not without its own problems, the high volume of people reported as using these services indicates that there is a growing demand for psychological support by both those who are able to speak English, as well as those who need the help of an interpreter. Given that the NHS is the biggest employer of psychologist in the UK, these changes have meant that practitioners are now required to

evaluate and extend their clinical practice to include working with people from different cultures and languages to themselves. In order to make this possible, whilst employed by the NHS, practitioners are expected, where necessary, to work alongside bilingual interpreters. This being the case the aim of this study was to contribute to the existing literature on how practitioners work with interpreters when offering psychological support to those clients who are either unable to speak English or feel more comfortable communicating in their native language.

5.5 The Implications of the Findings.

This research suggests that a tension exists in the clinical set up of the triad. Furthermore, the findings highlight a number of factors that possibly contribute to the build up of this tension. Firstly there appears to be structural flaws within the IAPT services. For instance, although the idea is for practitioners and interpreters to work alongside each other, there appears to be little or no opportunity for either of these two professionals to receive training in how best to work as a team within the triadic system. Such training could help enhance interpreters' awareness of mental health issues and the practice of therapy, as well as improve the development of the co-worker relationship. Furthermore, the IAPT services might consider offering a number of interpreters, who are able to speak the more common languages spoken within a given community, more permanent contracts. This might help improve the social prestige of the profession of interpreters and consequently make it easier for practitioners to consider interpreters as part of the wider clinical team.

The advantage of having permanent in-house interpreters would also mean that the service is more culturally apt as team meetings could include discussion around the cultural appropriateness of certain clinical models and practices. This might help bridge gaps in practitioners' understanding of different cultural values, rituals and behaviours which could

in turn improve clinical diagnoses and mean that psychological interventions are culturally appropriate and relevant to the clients' world. As such the practice of counselling psychology can remain loyal to its humanistic roots in meeting the clients' needs and the NHS IAPT service would be more person-centred in its practice. Moreover because these and other matters can be part of ongoing team meetings and service development, practitioners will not have to spend time developing a working alliance with interpreters or have to allocate extra time before or after sessions to attend to cultural matters such as beliefs or values about mental health and well-being.

Based on the findings of this study another area that needs addressing is the academic curriculum and clinical teaching on professional courses. The number of participants who indicated that their initial professional training did not cover matters pertaining to how to work cross-culturally with the support of an interpreter was concerning. The dominant models of therapy are entrenched in western philosophy and language. Bassnett, (1991) has highlighted the difficulty associated with finding equivalent words or concepts across different languages. In addition some authors argue that the availability of meaning is culturally embedded and context bound with language acting as a means for accessing meaning (Cronen, Johnson, & Lannahan, 1982; Geertz, 1973). As such, the question then becomes more about how practitioners can use theory in a culturally appropriate way. This question can be addressed to some extent by providing practitioners, during their initial training, with a foundation for better understanding cultural aspects of therapy. Perhaps trainees would be better equipped to work with interpreters if they took a more social constructionist (Burr, 2003) approach to the triadic practice of therapy. This would involve developing a shared context between the members of the triad to find more effective and culturally appropriate ways of applying psychological theory to clinical practice. It is

possible that taking such a stance to clinical work would help practitioners to be more mindful of cultural issues, particularly when considering the appropriateness of certain interventions, an area which some authors claim needs improving (Solomon, 1997; Thompson, 1999).

Overall, this study has pointed out some of the possible factors that contribute to a build up of tension within the clinical context of a triad. The anxiety that participants experience when working in this style of therapy could be reduced if there was more in the form of training that supported both practitioners and interpreters when working together. In addition, this working relationship could be improved if interpreters were better integrated within the IAPT services and were considered as part of the clinical team. In turn, these might go some way to abating practitioners' anxiety so that they are not left feeling de-skilled and needing to retreat to a more dogmatic, authoritarian position within this area of their work.

5.6 Limitations of the study and Alternative Explanations for the Findings.

As with any other qualitative and quantitative research that aims to explore human nature within a given social context, the findings of this study must be considered in view of its limitations. At no point during this study was it the intention of the researcher to claim that the findings presented here represent a truth, or to make generalised statements on the basis of these findings. Rather, it is hoped that these findings are regarded as representing this group of participants in their particular culture and social interaction with the researcher within a certain social context and time. In addition, the findings and ideas presented are the result of the researchers' subjective interpretation of the data and hence influenced by the researchers' particular culture.

5.6.1 Critiquing Social Constructionism and Symbolic Interactionism

Although the methodology used in this study has enabled an in-depth analysis to be carried out on the data, taking a wholly social constructionist perspective might be problematic. For instance, if as the theory of social constructionism suggests, all aspects of our social world are determined and limited by social constructs and constraints, then it would follow that these findings themselves are a form of social construction. Yet Lyddon (1998) argues that the theory is written in a manner that implies it is a 'real truth'. Also, according to Charmaz (2006) theory '*emerges*' from the data. This seems to imply that there exists a theory within the data which is waiting to be revealed through data analysis. This appears to be at odds with the social constructionist and symbolic interactionist idea that theory is created or generated through inter- and intra-dialogue. Consequently, the alternative term of theory being '*constructed*' was used to better reflect the social constructionist and symbolic interactionist principles that underlines this study.

5.6.2 The limitations of the findings

The findings of this study are based on data analysis of eleven in-depth interviews. Although as stated in chapter 3, because of time and resource limitation theoretical saturation (Charmaz, 2006) was not a principle endorsed by this researcher, the researcher nonetheless acknowledges the potential drawback of such a small sample size when considering the implications of the findings. However, by the same token, if as the social constructionist perspective suggests given the many numerous ways of viewing or explaining a particular phenomenon reaching theoretical saturation might not be achievable in any research (Burr, 2003). Furthermore, it could be argued that, if participants' accounts of a phenomenon are socially constructed with the researcher and embedded in social discourses, previous interactions and symbols that have been negotiated between people,

groups and societies and the influence of existing literature, then it might be that the data collected through interviewing the eleven participants can go some way towards developing and constructing the categories in a way that is more inclusive of the social understanding of the phenomenon in question. Overall, with only eleven participants, it is not possible for the researcher to claim that theoretical saturation was achieved in this study. Consequently the researcher ceased data collection when it was considered that the data analysis had reached sufficient depth in each category to construct a meaningful coherent theoretical model from the available material.

On a further note, in contrast to Glaser's (2002) claim that it is possible to avoid personal views from intruding onto the data, the researcher in this study accepts her own potential influence at each stage of the research. The researchers influence is apparent over the way the data was collected, condensed and constructed into a theoretical model. The findings presented here are therefore the product of the researcher's decisions and interpretation of the data.

5.6.3 Reflexivity

As mentioned elsewhere, although it was the aim of the researcher to remain true to the participants' accounts it is inevitable that to a certain extent the findings are representative of the researchers' subjective values, beliefs and interests. In an attempt to account for the involvement and potential influence of the researcher a log book or research journal was kept. Here the researcher recorded personal thoughts and feelings after each interview and also noted any ideas about the meaning of the data.

On reflection this study took the researcher on a personal journey. The initial reason for wanting to carry out this study was to explore the opportunities available to those clients

for whom English is not their first language. Given that the researcher is from a certain ethnic background she was familiar with the lack of opportunities available for people who require mental health support, but are unable to receive the support available owing to language barriers. As a result of lived experience the researcher empathised with the client, knowing how it is to be in a position in which one is silenced and made to feel like a second class citizen, without having the same rights and opportunities as others. However, in the process of the initial few interviews the researcher began to empathise with the participants' struggles in offering therapy within the triad. Here the researchers' own experience as a psychologist in training entered the interview process and there seemed to be a shared experience between the researcher and the participant in the need to work within a framework of professionalism and the demands and pressure to meet certain social expectations. Moreover, the need to manage ones' own anxieties and struggles in clinical practice, in other words, silencing the clinicians scared inner voice in an attempt to appear in control and confident in ones' practice echoed the researcher's personal experience of feeling isolated in her earlier stages of training. However, at times when the participants spoke of the interpreter as the voice and almost dehumanised that person, the researcher was pulled back to those occasions in the past where she had acted as an interpreter for a family member or friend and remembered the difficulty of being in this role. The researcher recalled the difficult task involved in interpreting between two languages, and at times feeling that the effort and struggle involved in this task was not necessarily acknowledged or appreciated. Overall, during the process of this study the researcher resonated with the different positions of the three people involved in the triad. Ironically, the notion of feeling excluded, silenced and disempowered was something that seemed to relate to the different positions, be it the practitioner, the client or the interpreter.

At times, the researcher's familiarity with the different positions made it hard to step back in order to see things from a different perspective. This was particularly so in the process of analysing the transcript. Meetings with research supervisor helped to achieve a sufficient distance from the material to see the broader connections within the data. However, the lived experience of the researcher and her own bilingualism no doubt played a part in the findings of this study. Indeed, it might be that had the study been conducted by a researcher from a different culture, gender and experience to that of the researchers then the findings could have been different.

5.6.4 Impact of the Researcher and Participant dynamics and the Interview Process

As well as the influence of the researcher subjectivity on the findings, there is also the impact of the relational dynamics between the researcher and the participants that requires further consideration. There is no way of knowing how the participants experienced taking part in this study and entering a dialogue with the researcher regarding their clinical experience of the triad. Rosenthal (1976) highlights that the researcher's psychosocial attributes, such as their anxiety, authoritarianism, warmth or hostility has a potential impact on the responses his or her participants provide. Certainly, from a social constructionist perspective the perceived social role of the researcher, within the context of a research interview, as held by the participant, and vice versa would have an influence on the relational dynamics and specific interaction taking place. In effect the participants' perception of the researcher as a trainee counselling psychologist exploring clinical practice of the triadic system, might have given rise to a need to appear more in control of the triadic situation and be seen as a competent practitioner.

In addition, all the participants were interviewed within their usual working environment in the context of the NHS primary care surgeries. Whilst being in their familiar environment

may have helped participants to feel relaxed, the fact that this was an NHS setting might have made participants feel obliged to take the more authoritarian position. The medical model is particularly powerful within the setting of primary care general practices and some of the participants indicated that this reflects the overall culture of the NHS. The connotation of the medical model is that the practitioner holds specific knowledge and skills that places him or her in a certain position of power which do not necessarily sit well with the humanistic roots of counselling psychology (Foucault, 1980).

Overall, both the meaning the participants attached to the interview and their perception of the researcher, as well as the NHS context in which the interviews were carried out might have influenced the way in which participants chose to present their clinical experience of working in the triad.

5.6.5 The Sampling Procedure and the Impact of the Sample Population

Both the recruitment method and the sample population of this study could be questioned. Although attempts were made to locate practitioners and other services that offered therapy with the support of an interpreter these efforts were fruitless. As a result the researcher sought ethical approval from the NHS trust to take advantage of several IAPT services that did indeed work with interpreters in offering psychological support. Consequently this research was carried out in only five IAPT service teams and caution is needed when considering the implications of the findings of this study. Not all IAPT services are structurally the same. These particular services offered person-centred, psychodynamic and cognitive behavioural therapy and recruited counselling psychologists, clinical psychologists and therapists from different counselling orientations. It is possible that practitioners working in different IAPT services may have different experiences of working with interpreters as would those practitioners that work either in the voluntary

organisations or hold private practices. Although the difficulty expressed by the participants in this study does reflect other mental health literature on the problems associated with working with interpreters (Tribe, 1999; Raval, 2000; Raval & Smith, 2003; Tribe & Raval, 2006) it is not possible to make generalisations regarding this area of mental health work based on the findings of this study.

Furthermore, once ethical approval was granted participants were self-selected through replying to an initial e-mail that gave some general information about the researcher and the purpose of the study (see Appendix VII). It might be that those practitioners who volunteered to take part did so because they have a particular interest and hold certain views on the subject that are different from other practitioners' views and experiences of working in the clinical context of a triad.

The data generated from the interviews represents the implicit and explicit attributes of both the researcher and the participants and the influence of the contextual factors that played a part in the interaction that took place. Therefore both this interaction and the results of the data could have been different if any of these factors were different.

Consequently, the results of this study were dependent on the background and interests of both this particular researcher and participants from these particular IAPT services within a particular culture and time.

5.7 Suggestions for Further Research and Conclusions.

This study has explored practitioners' experience of their clinical work carried out with the help of an interpreter from a social constructionist and symbolic interactionist stance. In doing so it has highlighted several key areas that are associated with the triadic system of therapy. In particular the findings suggest that the co-worker relationship between the

interpreter and the practitioner needs further attention as it appears to be crucial to the quality of the service offered to clients with limited spoken English. It might be that the level of engagement and therapeutic progress that is possible in the therapeutic relationship is dependent on the development of a co-worker relationship between the practitioner and the interpreter.

Due to time and financial limitations it was not feasible to represent the other side of this co-worker relationship, but future research might explore how interpreters experience working with psychologists and therapists. This would offer a more rounded and in-depth understanding of this co-worker relationship and tease out what is necessary to support these two professionals to work together as a team in offering a service. Future research could identify the training needs of both these professionals and try to organise training to match this need.

A further extension would include research aimed at identifying how viable current models of therapy are when working with clients that hold different values to those of the western world and how relevant certain notions of therapy are to the practice of the triadic system of therapy. It could be that an alternative model of therapy is developed that views the therapeutic work as consisting of a triad and thus is able to account for the influence of the interpreter rather than consider the therapeutic relationship as being inclusive to only that of the client and the practitioner. Such research could help promote the clinical practice of therapy to be more inclusive in its nature and potentially defuse the tension within the triadic practice of therapy.

Finally, it would be beneficial to widen the sample population of future research to include practitioners and interpreters working in other public and private sectors of mental health.

This will advance the findings presented here and represent a broader understanding of this

social phenomena. It might be that outside the demands of the NHS, practitioners and interpreters have developed a way of working that is overall more beneficial to all the members of the triad.

In conclusion, the findings of this study suggest that there is a tension in the clinical practice of the triad. Participants in this study appeared to struggle in how to work with interpreters in offering therapy to clients with limited spoken English. This struggle seemed to be centred on two opposing styles of clinical practice. On the one hand practitioners appeared to want to hold onto the traditional dyadic practice of therapy which offered familiarity and a sense of reassurance, whilst also recognising the need to acknowledge the importance of the interpreter and work in a more inclusive triadic style.

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Appendix I



The research for this project was submitted for ethics consideration under the reference PSYC11/020 in the department of psychology and was approved under the procedures of the University of Roehampton's Ethics Committee on 13th June 2011

Ethics Application

Applicant: **Adalet Erbil**

Title: **The Therapeutic Triad: Practitioners' experience of working with non-English speaking client with the aid of a bilingual interpreter**

Reference: **PSYC 11/ 020**

Department: **Psychology**

On behalf of the Ethics Committee I am pleased to confirm that your Department has approved your above application subject to the following minor conditions:

As these are only minor conditions it is assumed that you will adhere to these conditions for approval and therefore we do not require a response. We do not require anything further in relation to this application.

Many thanks,

Jan

Jan Harrison

Ethics Administrator

Research and Business Development Office

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E: Jan.Harrison@roehampton.ac.uk

Appendix II



Barnet, Enfield and Haringey 
Mental Health NHS Trust

Friday, November 25, 2011 4:12:18 PM

Hi Adalet,

I am writing to say that your proposal has been accepted. Congratulations. The committee had the following recommendations relating to the research:

- It may be difficult to get clinicians to give up to two hours of their time; therefore, it is recommended that you seek other participants from outside IAPT. This may also give you a wider variety of clinicians and a more representative sample.
- It was thought that 10 participants is a very high number. The committee suggest that fewer (e.g. 6-8) might be more feasible.

Adalet, if you have any questions please contact me by email or phone.

Best wishes

Jerome Tierney

Appendix III

PARTICIPANT CONSENT FORM

A Qualitative Study of Practitioners' experience of working with bilingual interpreters
in providing individual psychotherapy to clients with limited spoken English

Considering the increasing media attention given to current waves of people migrating across ethnic communities and country borders; the issue of the practitioner and client not sharing the same language has surprisingly received little attention in the mental health literature. The main remedy to the problem has been to recruit an interpreter. Although this step has helped to open opportunities around the immediate problem it has created other difficulties.

The focus of this study will be to explore practitioners' experience of working with bilingual interpreters in providing individual therapy to clients with limited spoken English. The study proposes a qualitative enquiry, employing Constructionist Grounded Theory method to increase awareness of issues of therapy in a triadic situation (practitioner-client-interpreter).

As a therapeutic practitioner with a minimum of 12 months post qualification clinical experience you will be requested to take part in a 60 minutes interview, exploring your personal experience of working with bilingual interpreters in providing individual therapy to clients with limited spoken English and your understanding, thoughts on how this may change the therapeutic relationship. All interviews will be digitally recorded and transcribed.

The transcript, or extracts, may appear in the researcher's doctoral thesis and in publications arising from it. The recorded data may be heard by a supervisor and others who might be involved in examining the thesis. Any documents with identifying details will not be available to view by anyone other than the researcher.

Everything you say will be treated confidentially. However if there is concern over physical harm to yourself or any other person than the researcher is obliged to discuss this with you; and where necessary take appropriate action in accordance with the ethical guidelines of the British Psychological Society. You are free to

withdraw from the research at any point and all data relating to you will be deleted or destroyed.

I look forward to your contribution and appreciate your availability and commitment to participating in this study.

Adalet Erbil

Department of Psychology

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Whitelands College

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SW15 4JD

Email: a.erbil@roehampton.ac.uk

Tel: 000000000000

Consent Statement:

I agree to take part in this research project. I am aware and understand the nature of this project and what is being requested of me as a participant. I give permission to be interviewed for the purpose of this project, for the interview to be recorded, the interview to be transcribed for data analysis and agree for the data generated by this interview to be used towards any professional publications. I am aware that I am free to withdraw at any point. I understand that the interview will be kept confidential and that my identity will remain anonymous in the publication of any findings arising from this research project.

Signature

Date

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Director of Studies or you can also contact the Head of Department.

Director of Studies Contact Details:

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Appendix IV



The Interview Schedule:



Can you please tell me your experience of providing individual therapy to clients with limited spoken English with the aid of a bilingual interpreter?



In what way, if at all, does working with a bilingual interpreter influence your clinical practice?



Can you tell me about the type of training you have received either prior to working with a bilingual interpreter or following your experience of working in this way?



Could you tell me a little about the sitting arrangement of the client, the interpreter and yourself?

Appendix V



Participation Debrief:

Participant Number:

A Qualitative Study of Practitioners' experience of working with bilingual interpreters in providing individual psychotherapy to clients with limited spoken English

Thank you very much for your participation in this study. Your contributions are greatly appreciated and valued towards understanding practitioners' experience of providing individual therapy to clients with limited spoken English with the aid of a bilingual interpreter.

Data gathered during this interview process will be held securely and anonymously. If for any reason you wish to withdraw from the study, please contact the researcher with your participant number (above) and all data relating to you will be deleted or destroyed.

If you feel troubled by your participation in this study and feel that you require further support and information then please do not hesitate to contact the researcher. If you do not find that suitable then contact the Director of studies and Head of Department. All contact details are given below. Alternatively you may wish to raise the matter with your supervisor. Finally, The British Psychological Society provides guidelines for practitioners working with interpreters in health settings.

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Appendix VI

Participant Confirmation of Handling

A Qualitative Study of Practitioners' experience of working with bilingual interpreters
in providing individual psychotherapy to clients with limited spoken English

Please sign below to confirm that:

-  This interview has been conducted professionally and ethically.
-  You have been informed of how the data will be treated and stored.
-  In the event of needing to explore issues that have arisen from participation in this interview you have established follow up points of contact.

Participant

Name.....

Signature.....

Date.....

Researcher

Name.....

Signature.....

Date.....

Appendix VII



Participant Recruitment Poster:

A Qualitative Study of Practitioners' experience of working with bilingual interpreters in providing individual psychotherapy to clients with limited spoken English

My name is Adalet Erbil and I am a student of Roehampton University. I am in the second year of a PsychD in Counselling Psychology and am undertaking a piece of research that will contribute to the completion of my professional doctorate.

The focus of this study will be to explore practitioners' experience of working with bilingual interpreters in providing individual therapy to clients with limited spoken English.

The study will involve a single 60 minute, one-to-one interview at a time and place that will be convenient to participants. Including an introductory space and debriefing period, the whole process will take a maximum of 90 minutes. Participants are required to be a therapeutic practitioner with a minimum of 12 months post qualification clinical experience of working with clients with limited spoken English with the help of a bilingual interpreter. The interview process will be kept open so participants are free to speak of their experience without feeling obliged to answer specific questions.

All data gathered during this study will be held securely and anonymously. If you wish to withdraw from the study you may do so at any point during the interview or data collection and all data relating to you will be deleted or destroyed.

If you are interested in this study and feel that you would like to participate or have any questions then please feel free to contact me:

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Thank you for your Interest

Appendix VIII

Diagrammatic Representation of the Findings:

The following diagram illustrates the theoretical model. It shows how the focused codes, subcategories and categories are considered as being in relation to each other as well as to the core category. The three members of the triad are represented by the arrows at the top of the diagram along with the perceived social attributes of the practitioner and the interpreter. In the centre of these arrows is the core category, with the two main categories illustrated by the two clouds on either side of the diagram. The subcategories (as illustrated by the circles) filter into the two main categories, and the focused codes (illustrated by the square boxes) filter into these.

Appendix IX

The example matrix below demonstrates how the initial codes, focus codes and sub-categories were developed from the primary interview data. Examples are given for each of the core categories.

Main Category 1: The therapeutic relationship perceived as a 2-way dyadic process.

Sub-category	Focus Code	Initial Code	Raw Data
The triad –An impediment to clinical practice	Importance of having the first contact with the client, rather than losing the immediacy in the process of translation	<p>Having to understand the clients world/emotions through the interpreter</p> <p>Going beyond language to connect with the client's emotional material</p> <p>A sense that something gets lost in translation</p>	<p><i>if I'm saying something that's got to go to a third person and then go back and then to the person I'm talking to and then the person that I'm talking to sends it back to the interpreter and back to me again, it's not the same at all.</i></p> <p><i>I try to get it so that the client's speaking to me so that I can really feel it first and then perhaps the content... if the emotional content isn't conveyed correctly by the interpreter it doesn't matter so much if I've had that first contact and felt it</i></p> <p><i>Sometimes I suppose I question what I might be missing, with having an interpreter, because the question gets</i></p>

Sub-category	Focus Code	Initial Code	Raw Data
			<p><i>..said to the interpreter as you know, and then it gets fed back to the client, and sometimes I almost wish that I could speak that language.</i></p> <p><i>I'm pretty sure I miss things. I'm pretty sure I do not get everything back.</i></p> <p><i>I did a lot of thinking about communication, you know, other things apart from language, or the use of a little bit of language, and very much focusing on what was going on emotionally</i></p>
	Practitioners reluctance and discomfort of having to work with interpreters	<p>Finding other ways to connect with the clients narrative</p> <p>Reaching a point of never being comfortable with working through an interpreter</p> <p>Working through an interpreter is an</p>	<p><i>I'm never comfortable, is, I guess is what I would say I am now, never comfortable with working through an interpreter, if that makes sense.</i></p> <p><i>Working with interpreters for me,</i></p>

Sub-category	Focus Code	Initial Code	Raw Data
	<p>The structure of the triad feels like an interview whilst the dyad feels natural. What does this say about familiarity in terms of therapeutic practice? Or the rules of social interaction.</p>	<p>impediment, slowing things down</p> <p>Happy to avoid working with interpreters- it's hard work!</p> <p>The triad feels like an interview rather than a therapy session. The natural flow of the dyadic relationship is 'interrupted' as the information by the client and the therapist needs to be translated by the interpreter</p>	<p><i>.. it's definitely an impediment and it slows things down.</i></p> <p><i>I think it is still something, working with interpreters, that overall, I am happy to avoid. I don't think I do avoid it, but I'm happy to avoid it, because it brings a certain heart sink about it, because it's hard.</i></p> <p><i>The other thing I've noticed is that it does feel like an interview. It's not like a counselling therapy session where the flow is, is free, the free association comes out naturally, and you can observe the dynamics in a more kind of liberated way. It's more like an interview where there's an expectation that the counsellor talks, interpreter translates, client responds. Again, client talks, interpreter translates, counsellor receives, it's like the circle of verbal interaction.</i></p>

Sub-category	Focus Code	Initial Code	Raw Data
Difficult to establish a therapeutic alliance with the client	A need to hold onto the 'ideal' dyadic relationship	<p>The structure of the triad doesn't fit well with the traditional idea of building therapeutic relationship with the client</p> <p>Having to divide attention potentially affects the therapeutic alliance</p>	<p><i>It's never going to be the same as when it's just two people in the room. So having a third person there, I feel, is making it more difficult to establish an effective therapeutic relationship. It's not impossible to do it, but it's making it more complicated</i></p> <p><i>What is a good therapeutic relationship? I think a good therapeutic relationship is when the client, when the patient feels that the therapist is there for her or for him, and they've got 100% attention. You know, that... there's fifty minutes when all the attention is for the client. The therapist is there to pay attention to the client, and I think that, in itself, is such a precious situation, you know, that that works. Now, with somebody else in the room, as a therapist, you have to divide your attention obviously. You've got to pay attention to what's happening with the interpreter,</i></p>

Sub-Category	Focus Code	Initial Code	Raw Data
		Concerns and anxiety about managing the three-way process	<p><i>..between me as a therapist and the interpreter, what's happening between the interpreter and the patient, and then me and the patient, so I can't give really 100% to the patient because, you know, there is other things to take into account as well and I think that the patient will experience that, will notice that.</i></p> <p><i>I was quite curious as to how I would manage that sort of three-way process. I was also, I suppose, anxious as to how it would go, how it would affect the establishing of the relationship.</i></p>
The triad slows the therapeutic process	Time experienced as frustrating, tiring or an opportunity to reflect	Time experienced as being frustrating or a space to reflect	<p><i>It's [the triad] tiring.. you're having to watch out for a lot more, and the pace is generally slower, and that's quite tiring.</i></p> <p><i>one of the advantages of working with the interpreter, which comes out of this sort of slowness, which can be a little</i></p>
Sub-Category	Focus Code	Initial Code	Raw Data

	Assumptions and concerns around the therapeutic pace and its effectiveness	The slow pace of the triadic process creeps doubts on the effectiveness of the clinical work	<p><i>..frustrating, is that you do have time, so that's the silver lining of the process, the time to observe and think.</i></p> <p><i>Sometimes I kind of think oh I wish I could just get on with this, so there's a bit of frustration sometimes.</i></p> <p><i>The pace of the session takes a lot of getting used to, because it is, it can be quite frustrating, slow, this, to-ing and fro-ing. So there can be concern about how effective one is going to be or, you know, how successful it will be.</i></p>
Loss of immediacy	The difficulty to connect with the client in the triadic relationship	The difficulty to connect with the client. Where words fail the eyes connect.	<p><i>I always make a huge effort to try to maintain eye contact with the patient even when there is communication going on between the patient and the interpreter. It's tempting, to just to think about</i></p>

Sub-Category	Focus Code	Initial Code	Raw Data
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			<p><i>..something else or to just move your head slightly... but I think it's wrong. I will... You know, I know that I will then miss out, but also I will, you know, know that the patient will notice that my attention is wandering off to somewhere else. Maybe that's one of the most difficult situations, one of the most difficult aspects of working with an interpreter, how to maintain eye contact.</i></p>
	Wanting to keep a level of dyadic immediacy	Wanting to maintain a level of direct immediacy with the client by using other forms of communication to connect	<p><i>Reading, not just listen to what the interpreter is saying to the client, but actually reading the interpreter's body language, reading your client's body language, seeing if there's any more than what's been said, seeing if a client is expressing some facial expression that you might need to elicit what else is going on there. I always use my hand, I use facial expression so that,</i></p>

Sub-Category	Focus Code	Initial Code	Raw Data
	<p>The structure of the triad;</p> <p>loss of language</p> <p>loss of immediacy</p> <p>loss of authenticity</p>	<p>Loss of authenticity</p> <p>The immediacy is lost in the triad</p> <p>‘As if’ moment gets lost in translation</p>	<p><i>..before the interpreter can even say anything, they’re kind of understanding me as well and, you know, and I find that really works, the body language</i></p> <p><i>You think what you’re going to say next and then say it. And I think when you do that, it tends to lose its authenticity.</i></p> <p><i>It slows the process of working with somebody down, because the immediacy is taken away.</i></p> <p><i>In person-centred terms, that ‘as if’ moment doesn’t really happen because, it’s as if I’m in that person’s world through an interpreter, so I’m also in the interpreters world I guess, because it’s got to go through them.</i></p>

Sub-Category	Focus Code	Initial Code	Raw Data
Implication of the third person on the process of therapy	The structure of the triad effects clinical practice	<p>Keeping it basic and working at the surface level</p> <p>Difficult to move beyond the surface material</p> <p>Making assumptions about which therapeutic modalities works better in the triad</p>	<p><i>I sometimes feel it can be more difficult to go into the more complex concepts.... So I might, at times, just make it more about the basics.....and keep it more to a sort of five areas model, which is perhaps more surface level, than going into the more kind of in-depth work.</i></p> <p><i>I think there are limits to the work that can be done from a psychodynamic training. ... sometimes working psychodynamically when you want to take things down and down and down to different levels then sometimes you're stopped a bit too early before you've been able to really help explore a particular dynamic, either by time or the limitations of the work. So I find it's much more... working with interpreters is much more confined to more person-centred and supportive work...</i></p>

Sub-Category	Focus Code	Initial Code	Raw Data
	<p>The triad is experienced as being restrictive and limited to working at a basic, surface level of therapy</p>	<p>Triad restrictive to simple, basic therapeutic work difficult to cover more complicated material</p> <p>The structure of CBT creates obstacles for working in the triad- is the grass greener on the other side?</p>	<p><i>..than really explorative, working with the unconscious and the transference or whatever.</i></p> <p><i>I think I still feel restricted though, in terms of what I'm able to do, because I feel I probably have to keep it quite simple for it to pass through translation. If it starts to become too complex, a lot of the interpreters aren't trained in mental health work, so I think they translate literally. So the sort of subtleties you get with mental health work, I think are lost within translation, so I always will keep it very simple.</i></p> <p><i>CBT is, it's very structured, and almost like quite formulaic. It's quite difficult to pass that through translation as well, so I guess there are a lot of obstacles, whereas you wouldn't get that in other disciplines, you know, in counselling or psychodynamic.</i></p>

Sub-Category	Focus Code	Initial Code	Raw Data
The personal preferences of the interpreter influences how the clients material is conveyed	The interpreter selecting what information to convey	<p>Not being transparent about possible existing cultural barriers</p> <p>Filtering information on grounds of personal conclusions or assumptions before offering its interpretation</p> <p>The influence of the interpreter on the client</p>	<p><i>Cultural issues can get in the way, like a male interpreter and a female client, and they [interpreters] don't always make that clear to me as a practitioner.</i></p> <p><i>Something can be said and they will kind of filter it before they repeat it back to me, for various reasons. It might be because they don't... they might be embarrassed about it themselves, about saying it; they may feel that what the client is saying is rude. I mean, I've had that. And they might also think that I would be embarrassed by what is being said.</i></p> <p><i>What I would see is a client behaving themselves rather than being in therapy because they felt that they were being judged by the interpreter.</i></p> <p><i>It's someone else's perception in the middle, it's how</i></p>

Sub-Category	Focus Code	Initial Code	Raw Data
		Acknowledging that there is no active observer to a situation that does not influence what is being observed.	<p><i>..sometimes the interpreter may perceive our client's content and the way they would deliver it to us, I, I guess that it would be very, very different.</i></p> <p><i>It's not like a computer doing the translation, dramatically; it's someone else's perception. They receive my intervention or my verbal input, they process it and then they interpret it back to the client, but they don't always interpret or translate everything, it's what they judge, and this is very unconscious.</i></p> <p><i>The interpreter may be someone who's not psychologically minded, not used to erm, listening to those types of things and having their own judgements, and their own ideas about what's being talked about, and this can come out,</i></p>

Sub-Category	Focus Code	Initial Code	Raw Data
			<p><i>...this can spring to the session in lots of different ways, not consciously, perhaps unconsciously through the way the interpreter, the body language, how they're positioning themselves into the room, if they're late, they're not late, eye-contact, all those things.</i></p>
Matters concerning to professionalism	Feeling excluded and concerns about being left out	<p>Importance of feeling involved or being kept in the loop</p> <p>A sense of missing half the story</p> <p>Feeling left out of the conversation</p>	<p><i>So I will always make a point to say, I really need you to translate everything, even if you think it's not really relevant, I still... you know, I still need to know everything, what's being said.</i></p> <p><i>I'm pretty sure I miss things. I'm pretty sure I do not get everything back.</i></p> <p><i>Sometimes you just get that conversation between the interpreter and the client and you're almost kind of left to the side, to say, you know, as in, you're not part of the conversation.</i></p>

Sub-Category	Focus Code	Initial Code	Raw Data
	Lack of professional training in this area	<p>Learning by doing, trial and error system</p> <p>Lack of training leads therapist to feel deskilled</p> <p>Experience led understanding of working with interpreters</p> <p>Learning through trial and error</p>	<p><i>It's just an area I'd really like to know more about. It's like, there seems to be a sense of just learning by doing, rather than learning by example, or learning by training, or learning by professional development. It's a kind of trial and error system.</i></p> <p><i>It's a huge discrepancy..... I've not seen any advertised in the time I've been practicing, in terms of how to develop your skills of working with non-English speaking clients, and also, using an interpreter, you know, the skills of getting the most out of a session with that set-up, I've never seen any modules or training provisions on that either, post-qualification. So I would really welcome it.</i></p> <p><i>Pending any training, I just got stuck in..... So I learnt on the hoof really.</i></p> <p><i>I obviously learnt an awful lot more through trial and error.</i></p>

Sub-Category	Focus Code	Initial Code	Raw Data
		Lack of training in the area of working therapeutically in a triad means that often therapist's struggle in this area is not acknowledged and perhaps consequently therapist avoid working with clients who may require an interpreter	<p><i>We had probably about, you know, ten minutes about cultural stuff, it was very bad.....You sort of got on with it, and people seemed to be really pleased that I was prepared to do it. It was again, Cinderella stuff, [the clients who require an interpreter is considered as poor Cinderella] which I thought was awful.</i></p> <p><i>The reality is that, no, we haven't been taught, I haven't had any experience or any training on this type of work. Because there's so much struggle between us, that goes unacknowledged between therapists, about, and I'll tell you something, I know, and I notice that people tend to avoid working with them [interpreters].</i></p>
	Practitioners anxiety, Feeling exposed, deskilled and disempowered	Feeling deskilled and questioning ones professionalism	<i>I suppose maybe a little bit more in the earlier days of, sometimes feeling relatively de-skilled, when it's not going well or there's just difficult silences going on, which</i>

Sub-Category	Focus Code	Initial Code	Raw Data
		<p>Feeling exposed by the presence of the 3rd person</p> <p>The therapist anxiety of not knowing what the interpreter is saying.</p> <p>Difficult to be in the dark and yet feel like a practitioner.</p>	<p><i>you'd much rather manage just one-to-one.</i></p> <p><i>We're not used to having a third person in the room, so that can feel quite sort of exposing. But I don't think it is really like that but particularly if you have a client who is really struggling or really silent, that, you know, would be a difficult session anyway, to have someone else there can be even more difficult.</i></p> <p><i>It's a bit scary because we don't always know what they're saying.</i></p> <p><i>It's very weird not to be understanding what's going on when you're wanting to be a therapist</i></p>
	Ethical issues regarding professional responsibility for the wellbeing and supervision of interpreters	Acknowledging the possible psychological burden interpreters are put under when working in a field they are not trained in.	<i>I know it's not easy and I try if I can to provide even a debrief after the session, even if it's just a kind of small chat on the way out or something, so that...</i>

Sub-Category	Focus Code	Initial Code	Raw Data
		<p>The impact of the client's material on the interpreter whom acts as the filter.</p> <p>The possible impact of the interpreter and the client having a shared experience, potential for vicarious victimization.</p>	<p><i>'cause they're not really... some of the things that are being said in the sessions are quite harrowing and they're not therapists and they've not been trained in carrying this stuff.</i></p> <p><i>If I'm affected by a client's distress, the interpreter is going to be as well. So I have to be quite mindful, and to keep a partial mind on how they're experiencing, because they become a filter, and sometimes, where they become a filter, they're the client and they can, you know, it's probably quite difficult for them to process things.</i></p> <p><i>I'm not sure always about the training of interpreters but, you know, they're facing emotional material that sometimes in assessment is very graphic, very detailed, very full-on, and sometimes it is a bit overwhelming and also I wonder sometimes if they're interpreting from</i></p>

Sub-Category	Focus Code	Initial Code	Raw Data
		Acknowledging that the interpreter can emotionally respond to the client's story	<p><i>..someone of their own culture and perhaps their own home country and how much of that is common; how much of that is a shared experience, and how difficult that is for the interpreter.</i></p> <p><i>Well, the interpreter is not necessarily someone from a psychological background, but you know, an interpreter, someone who is trained to translate it from one language to the other, so sometimes they might find the experience stressful, or they might be shy or embarrassed, so I have to contain their anxieties.</i></p>
	Issues about clinical trust and client confidentiality	Importance of trust and confidentiality	<p><i>It's really difficult to build a relationship and build trust and be confident that they will maintain confidentiality when you don't have that trusting relationship with them [interpreter]. So that's an issue. I don't think there's any comeback on them, if they do breach</i></p>

Sub-Category	Focus Code	Initial Code	Raw Data
		Concerns around confidentiality	<p><i>... confidentiality.</i></p> <p><i>I just think it's all very dodgy and very risky and....I don't know, and maybe I should be asking the question more, but I just don't know how bound interpreters are in confidentiality.</i></p>
		The clients concerns around confidentiality	<p><i>There are times when people whose English is just sufficient for a conversation that will come along and say I want to try because I don't want an interpreter from my own culture, from my own community, because I don't trust that it won't get back; what I'm saying to you will not get back to my community.</i></p>
		Client's perception of whose professional and the impact of this on providing a confidential space	<p><i>They trust we're professional, we're working in a professional world, but the interpreter is out there in the community with them, somewhere in the same community.</i></p>

Sub-Category	Focus Code	Initial Code	Raw Data
The NHS culture and its implications to the clinical triad	Not feeling supported or valued	Feeling isolated, having to manage without feeling supported.	<p><i>When I started working I just felt like we had to manage but I wasn't coming from any informed position.</i></p> <p><i>There is so much to be done, there's so much, so many struggles within the politics, we lose the bottom line this is getting lost in translation, the political translation of the NHS. Maybe you have the luxury to explore these issues as a trainee, working in a placement, a voluntary placement, where they will have the time to go through that with you in supervision, nice and openly, or at college if your lucky, but not at work. Work is a different world.</i></p>
	Lack of choice or control over ones clinical practice	Certain areas of clinical practice are not spoken of. Feels like it's a privilege to discuss clinical issues around working in the triad	<p><i>Given the choice, I would choose not to use an interpreter. I find it quite hard work.</i></p>
		Not having a choice over working with an interpreter	
		Having no choice, having to get on with it.	<p><i>To be honest, I just get on with things because, there isn't really an option.</i></p>

Sub-Category	Focus Code	Initial Code	Raw Data
	Difficulty of meeting service demands and those of the triad.	<p>More unlikely to get good outcomes from the triadic work which clashes with performance indicators.</p> <p>The demands of the NHS doesn't accommodate for working in the slow pace of the triad</p>	<p><i>As we're moving towards being outcome based, and there's much more pressure on getting good outcomes, the chances of getting a good outcome are much, much less. And often, you will run into more dead ends and more problems.., that sort of clashes with performance indicators and things, you know, that you're meant to go through a certain, you know, number of sessions with the client, so you, in a sense, can't slow down, even though you need to slow down.</i></p> <p><i>It's about reducing patient numbers, about working quickly, and as efficiently as possible, and that's the reality of the NHS.</i></p>
De-humanising the interpreter in an effort to stay in control and abate anxiety.	The role and importance of the interpreter minimised.	A need to feel in control.	<i>As therapist we are coordinators of the dynamics so we do tend to, at least I do, tend to take a leading role in that.</i>

Sub-Category	Focus Code	Initial Code	Raw Data
		<p>One's role defines who is in charge</p> <p>The therapist identifies with the role of being the knower the expert and taking the position of the leader within the triadic environment, but what about the knowledge that the other two members bring.</p> <p>Feeling one has 'ultimate' responsibility.</p>	<p><i>It's my role to judge what's going on and it's my role to decide whether a show of aggression or whether bad language is appropriate or inappropriate or whatever.</i></p> <p><i>You're the one that knows, has the techniques, the approaches and, so, you take the lead.</i></p> <p><i>Ultimately, I'm responsible.</i></p>
	Interpreter Vs. Translator or Machine Vs. Person	<p>Translation Vs. Interpretation</p> <p>Wishing that the interpreter was a universal translating machine.</p>	<p><i>I'm really quite strong even now about the difference between a translator and an interpreter and what I want is a translator, but what I get is an interpreter</i></p> <p><i>Apparently, in Star Trek, they have this multilingual computer that's in all the starships and so whatever alien race you are, you sit</i></p>

Sub-Category	Focus Code	Initial Code	Raw Data
			<p><i>..in a room and a computer would change your voice for you. That's the idea of it, but I just...I want my translator to do that. I want them to be a universal translating system.</i></p> <p><i>Their role is to be my voice, in a way, and it's not for them to add or omit anything I'm saying.</i></p>
The symbolic non-triangular sitting arrangement.	Wanting to keep the dyad through the sitting arrangement. The elephant in the room.	<p>Dyadic feel to a triadic set up.</p> <p>Triangular arrangement feel like the interpreter is part of the therapeutic dynamics</p>	<p><i>Sometimes, it might be about asking them to sit further back, so they're not in the eye line of the client or me...if possible, sometimes to sort of be sort of separate from, so there's kind of a sense of it's just the client and myself.</i></p> <p><i>What I'd prefer is if the interpreter is sitting just slightly behind the client and looking at me so that...if they're sitting in the middle then it's that triangular arrangement, in which the interpreter is part of the dynamics of the therapy.</i></p>

Sub-Category	Focus Code	Initial Code	Raw Data
		Does sitting behind the client somehow prevent/minimise the influence of the interpreter on the dynamics of therapy?	<i>They're sort of suggesting the interpreter sit just behind the client in psychodynamic, so it doesn't interfere with the, you know, it doesn't block the dynamic between the therapist and the client.</i>

Main Category 2: The therapeutic relationship perceived as a 3-way triadic process.

Sub-Category	Focus Code	Initial Code	Raw Data
Acknowledging the professionalism of the interpreter	Learning from the interpreter	Co-working can improve practitioner's cultural understanding. Co-working enables personal growth thus helps clinical practice become more culturally sensitivity.	<i>I've learnt masses from interpreter about cultures and, you know, they've [interpreters] added things to my understanding. There's been an immense amount of growth for me, because I've learnt more about culture and about the way people are socialised and educated in other parts of the world.</i>
	Acknowledging the dual role of the interpreter	The interpreter acting as a cultural broker.	<i>You can sometimes use the interpreter when the client's not there, obviously, to</i>

Sub-Category	Focus Code	Initial Code	Raw Data
	Complex skills involved in translating between languages and cultures	<p>The interpreter can offer a context for understanding the client.</p> <p>More than a word machine- a facilitator</p> <p>The role of the interpreter also requires an awareness of mental health issues</p> <p>Admiration for the interpreter's skills and abilities</p>	<p><i>..ask about the culture, and sometimes the interpreter will, tell you things that they've picked up, that I might've missed.</i></p> <p><i>It can be really useful to get some context from the interpreters.</i></p> <p><i>It's not just about passing words backwards and forwards, they're a facilitator.</i></p> <p><i>I've worked with a number of extremely good interpreters who are not only well trained, but who have an understanding of mental health issues, which makes a huge difference.</i></p> <p><i>I hugely admire most of the interpreters we use, because they have fantastic memories, and manage to, you know, allow the client to speak, but also to retain such a lot.</i></p>

Sub-Category	Focus Code	Initial Code	Raw Data
		<p>Not only translating words but also being able to convey the client's emotional experience.</p> <p>The interpreter goes beyond translating words, it's more skilled</p> <p>The therapeutic triad helps make therapy flexible and accessible to the wider communities</p>	<p><i>Some clients are so pleased when they're really listening, and really aware that, whatever they're saying is being, not just translated, but actually being told with the same expressions, sometimes even the same hand movements. So really trying to get across the meaning and the feel of it, that's very, very skilled stuff I think.</i></p> <p><i>I think it's too simplistic to expect interpreters to translate word for word.</i></p> <p><i>There is a large percentage of population who are referred to us and, you know, we have to kind of find a way of being flexible and providing them with the kind of maybe different kind of way of working. And then we need the interpreter to help us do this.</i></p> <p><i>If they allow some clients who are, you know, operating at almost Cinderella level in the country, some of these clients,</i></p>
	The triad opens up new possibilities for certain groups in society thus improves accessibility		

Sub-Category	Focus Code	Initial Code	Raw Data
The interpreter considered to be an asset		Working with interpreters makes it possible to challenge social stigma and discrimination	<p><i>...you know, where they're always being pushed down because they don't speak English, they don't have things properly explained, and then they miss out on benefits. One thing leads to another, and then they get angry, and then they get named as a bit of a troublemaker. One thing leads to another horribly. And, we're all human and make assumptions about people, and I think sometimes when you get behind all of that, with the help of the interpreter, I think that's very humbling as well and I try hard to hang on to some of that.</i></p>
		A good interpreter is perceived to be a real asset and the triad is experienced as being enjoyable	<p><i>I actually quite enjoy working with interpreters, because I think when they're good at what they do, they can be a real asset</i></p>
		Clients benefit from the triadic therapy	<p><i>I can definitely think of a good few cases where we've had such a great outcome with the client work, and what we've done has been so effective,</i></p>

Sub-Category	Focus Code	Initial Code	Raw Data
	The triad can help address issues of equal opportunities and improve accessibility of psychological therapies	<p>Makes therapy possible for people who are disadvantaged</p> <p>Seeing the bigger picture-improving access and advancing psychological support.</p>	<p><i>and at the end of it, the client has fed back to us that they felt they were able to make that progress because they felt comfortable, and they could trust both me and the interpreter. So it kind of...those times have really highlighted to me just how important the interpreter is.... So when it's gone well, the client definitely, you know, has benefited from it as well, and the interpreter's been, yes, just as important to the relationship as me in those times.</i></p> <p><i>If you think of the bottom line, which is to help this client, and improve access to therapy for clients who have been impoverished or have been damaged, who need it the most actually.</i></p> <p><i>If you think about the bigger picture, at the end of the day we're doing it to help these people, to improve access and see if we can give them a chance as well to, to have therapy or</i></p>

Sub-Category	Focus Code	Initial Code	Raw Data
		<p>Making it possible to go beyond a wall lifting therapeutic limits.</p> <p>The interpreter helps to open up the therapeutic space and bridges cultural gaps between the client and the therapist</p>	<p><i>...counselling, so if that's the ultimate aim, it's a very good thing to have interpreters working with us.</i></p> <p><i>when it really goes well, and you really have, you know, the interpreter's able to communicate not only the story, but really, you're really getting a sense of the emotions behind it, which you wouldn't have, it's a bit like you go beyond a wall that you wouldn't have got to without the interpreter, yeah, the limits</i></p> <p><i>This could be a little bit more of a westernised thing as well, but when you have two people from very different cultures, when you have someone from the same culture in the room as well, I think that tends to open things up a bit, and that, again, improves the dynamics.</i></p>
	Working across cultures can help practitioners challenge their own prejudice views and false assumptions	Facing and dealing with personal misconceptions	<i>It was like a personal experience to have a patient in the room that is from a culture whereby you've been</i>

Sub-Category	Focus Code	Initial Code	Raw Data
		Co-working helps challenge personal assumption, and gain deeper understanding of the client.	<p><i>brought up, in a way through Greek school, or through culture, let's put it, to have mixed feelings for, or, uncertainty, and I suppose that's been a personal experience for me, how do I manage what I've known and grown up with, and not allow that to spill into my therapeutic neutrality, being neutral in a way, which I suppose, I've managed it in a way where I don't allow myself to kind of I suppose I've dealt with my own misconceptions, or, my own views, cause I've had to do that, in order to be able to work in the way that I want to work with my client.</i></p> <p><i>In terms of, you know, the insights into cultures that one wouldn't get otherwise, and again, challenging one's own assumptions about those things, not even pretending to understand stuff that we can't, that's humbling stuff.</i></p>

Sub-Category	Focus Code	Initial Code	Raw Data
Importance of the co-worker relationship	Building a co-worker relationship between the practitioner and the interpreter	<p>When the working relationship is considered to be supportive the interpreter is perceived as adding value to the therapeutic work rather than as an impediment</p> <p>Team building between the interpreter and therapist, a similar process of building therapeutic alliance between the client and therapist a bi-directional process of what happens in the dyad taking place within a three way process</p> <p>The importance of the relationship between the therapist and interpreter, considered, at times, to be more important than the therapeutic alliance</p>	<p><i>It's very supportive. So I don't see her [interpreter] as an impediment in our sessions. I see her as somebody who adds value to my sessions and I guess that's a really important point.</i></p> <p><i>It takes a bit of communication and team-building between me and the interpreter while we're on the hoof with the client as well.</i></p> <p><i>Although the relationship with the client is important, I think my relationship with him was slightly more important, I think. I don't know how that goes with the literature. I think that relationship is, actually, maybe it's not equal, it may be my relationship with him was more important than with the client, because I was requiring him to be the guide and</i></p>

Sub-Category	Focus Code	Initial Code	Raw Data
		<p>The interpreter acting as an organic interface to enable the therapist to perform the work</p> <p>Pulling resources, and blurring the role boundaries to move the therapy forward</p>	<p><i>..facilitator for what was going on in the room.</i></p> <p><i>In a sense, yeah, we were almost merging, in a sense that it has to be sort of almost like one person. So I guess he would have to become, sorry, that's really mad, no, sorry. I guess he acts as a kind of interface almost, almost, not like a mask, but something that I can slip on, in a sense, to perform the work. And it's not an inanimate object, it's, you know, it's alive, it's organic.</i></p> <p><i>You almost become one. You pool your resources, in a sense, to move forward. And I guess it must be the same. But I guess as well, maybe it's about the boundaries between the three in the room, that they're not rigid boundaries, they have to have some blur and fluidity as the therapy moves</i></p>
	Importance of professional trust	Importance of working with an interpreter one	<i>There are some people who I now just completely relax,</i>

Sub-Category	Focus Code	Initial Code	Raw Data
		<p>is comfortable with can help to shift ones perception of the interpreter as an intruder</p> <p>Trust makes it possible for the role of the interpreter to be considered more than a translation machine</p> <p>Reaching a point at which working with an interpreter feels natural and enjoyable.</p>	<p><i>..you know, I kind of almost forget that I'm working with an interpreter now. Obviously they're still that third person and everything has to be said twice but I kind of have faith that they, you know, are making this process as seamless as possible.</i></p> <p><i>The interpreter I've worked with a long time and trust, I allow her to kind of put things in the spirit of the language and culture.</i></p> <p><i>It can get to the point where an interpreter, where the triadic relationship is going well, where I don't have to be thinking so much, oh, an interpreter's here. It can just feel like, you know, any other session and, okay, we just happen to have this extra kind of voice and maybe, you know, have a few more seconds where, you know, until I can hear back what the client's saying. But I can honestly say, a</i></p>

Sub-Category	Focus Code	Initial Code	Raw Data
		<p>Working with an interpret one is confident and comfortable with can enhance the therapeutic process</p> <p>Being comfortable with the interpreter enables freedom and flexibility</p>	<p><i>..lot of my most enjoyable client work has been with interpreters.</i></p> <p><i>When I worked with certain interpreters that I was confident with, you would feel the difference in the room, and you would feel the shifts happening.</i></p> <p><i>If I'm comfortable with the interpreter, I feel much freer and have much more flexibility.</i></p>
The symbolic triangular sitting Arrangement	The sitting arrangement of members of the triad as being symbolic of the therapist expectation of the interpreter's role within the therapeutic work	<p>The arrangement of the chairs represents the equality between the members of the triad.</p> <p>Acknowledging that the interpreter forms part of the therapeutic dynamics and this is symbolically represented in the sitting arrangement</p>	<p><i>I'm happy for the interpreter to sit between myself and the client, rather than behind or something, because I want them in the space too, to get the best out of that dynamic</i></p> <p><i>I would always have it that it is an equal amount of distance between the three of us. And the chairs are more or less, maybe, or kind of almost facing towards a centre point, so no one person is left out..... But I still think it's important that the chairs are equal, because the interpreter is just a</i></p>

Sub-Category	Focus Code	Initial Code	Raw Data
		<p>Symbolic meaning of the sitting arrangement of a triad-the interpreter is part of the relationship to be included</p> <p>The triangle helps to make the client feel comfortable</p>	<p><i>part of that relationship, so that's how I do it.</i></p> <p><i>I've heard horror stories of having interpreters sitting behind the therapist, and then the clients and they're just kind of like, almost, the client can't even see them, but just hear them [interpreter], and that to me kind of really, is a horror, horrific, in the sense that I, believe that they [interpreters] are part of the relationship, to be included.</i></p> <p><i>In order to make the client more comfortable, you know, I tend to make a triangle, but the interpreter will sit nearer to the client.</i></p>